‘Working together to keep children safe’

NORFOLK’S INDEPENDENT REVIEWING SERVICE ANNUAL REPORT
Professional profile of the Independent Reviewing Services – Independent Reviewing Officers and Independent Conference Chairs

The Team Structure is as follows:

1 Service Manager
3 Independent Reviewing Managers (IRM) – 2 have been in post since July 2015 and the third person started 29 February 2016. There was a management vacancy from November 2015 to March 2016.

The Service Manager reports to the Interim Assistant Director for Performance, and this line management provides total independence from the management of case accountable operational teams. The independence in terms of management structure is at a sufficiently senior level to meet the requirements of the IRO Handbook.

The independent Reviewing Officers (IRO’s) and Independent Chairs (IC’s) are all qualified registered social workers. They have a variety of social work backgrounds including: residential social work, child protection fieldwork, fostering and adoption, child and adolescent mental health (CAMHS), children with disabilities field work, probation, YOT and Family Group Conference facilitators.

There are 11.5 permanent IRO posts and for 4.5 posts for a period of 1 year to ensure caseloads do not exceed the guidance in the IRO handbook of a maximum of 70 cases per IRO.

At the beginning of April 2015, the average caseload was 92 and by 1 April 2016, the average caseload will be no more than 70 for any IRO.

We have an established pool of 7 sessional workers who have been covering a number of vacancies which have accrued over the year and will be used to ensure caseloads do not exceed 70.
There are 6.5 IC posts and currently we have 4.5 permanent IC’s. We are using an agency worker to cover one of the vacancies, whilst recruiting takes place. This level of stability has resulted in stable and manageable caseloads of approximately 80-85 children for each IC. This is a vast improvement on previous years when an IC’s caseload has been as high as 130-140.

The number of children and young people subject to Child Protection plans between 01.04.15 – 31.03.16, has gradually decreased. Historically, the number of children in Norfolk subject to Child Protection Plans usually averaged at around 550, currently it is 519.

There have been changes to the administration of LAC Reviews and CP Conferences which has resulted in the service only completing invites for initial LAC and CP conferences. Invites for on-going LAC Reviews and Review Conferences are undertaken by the social work teams (unless date of LAC Review or conference is changed from original date). There is an expectation in the Independent Chairing Service that IC/IRO’s perform a Quality Assurance function. One aspect of this is the completion of a Quality Assurance form (on CareFirst) following every Child Protection Conference/LAC Review. These monthly reports provide information about the quality of meetings and standard of the required paperwork and participation of young people/families and other professionals. If concerns are identified in respect of performance or practice issues, IC/IRO’s are required to challenge this, both informally and formally through the Dispute Resolution process. There is an expectation that this is recorded on CareFirst by the IRO/IC in order to evidence the challenge for LAC Reviews this is requirement of the national guidance (IRO Hand Book).
What's going well

- Caseloads are reducing to comply with the guidance in the Independent Reviewing Officer handbook.
- As soon as a child or young person becomes looked after they are allocated a named Independent Reviewing Officer. Wherever possible, this Independent Reviewing Officer, will stay with them throughout the period of time they are in the care of the Local Authority. Similarly, an Independent Chair takes on an Initial Child Protection Conference and follows the case through.
- We have responded to the latest Ofsted inspection (July 2015), which highlighted again capacity being a major issue for the service, by securing additional funding for 3.5 additional Independent Reviewing Officer's posts.
- A structure has been put in place to ensure that there is regular observations of LAC Reviews and Case Conferences undertaken by the Management Team using an agreed audit tool.
- All Independent Reviewing Officer’s and Independent Chairs have undertaken 7 days of Signs of Safety Training (S of S) and have implemented S of S ways of working within Conferences and LAC Reviews.
- A more effective use of the Dispute Resolution process is now being implemented which ensures monitoring is happening and that the outcomes for young people are improving. All disputes are now recorded on the child’s record.
- A named Independent Reviewing Officer ensures close liaison with our Legal Department, to help monitor and avoid drift in legal issues, revocation of Care Orders and of Placement Orders ensuring that appropriate legal status of the child/young person is obtained, and preventing drift in proceedings. NP Law has provided training for the Independent Chairs and Independent Reviewing Officer’s.
- There is a clear tracking system which assist’s Independent Reviewing Officer’s to monitor their cases in relation to Care Plans, Pathway Plans, LAC Health Assessments and PEP’s are in place.
- The Independent Reviewing Manager’s contribute to monthly performance meetings in each of the six localities, Independent Reviewing Manager’s contributes to and “imparts knowledge gained from this group” back to the team to improve performance across the LAC system.
- An Independent Reviewing Manager attends the Regional Independent Reviewing Officer’s Managers group. The ROM feeds back to the service developments, policy and research on a regional, national and Governmental level which informs the development of our own practice.
- There is a named Independent Reviewing Officer to undertake Remand Reviews to ensure there is expertise within this area of practice.
- There is a named Independent Reviewing Officer who is part of the Secure Accommodation Review process to ensure no young person’s liberty has been taken away, when other resources could meet their needs safely.
- The Quality Assurance forms have been redeveloped and are completed by Independent Reviewing Officer’s and Independent Chair’s after each review. The redevelopment of the QA is ensuring more in-depth monitoring of Care Plans, Pathway Plans and Progress Reports and Child Protection Plans.
- The ROM audits 2 reports from Independent Reviewing Officer’s and Independent Chair’s at each supervision session.
- We continue to use a RAG-Rating system to monitor the performance of Independent Reviewing Officer’s and Independent Chair’s in supervision.
- The QA Team provides regular feedback to the service from its audit activity and this is shared with individual Independent Reviewing Officer’s and Independent Chair’s. Also, members of the QA Team periodically join our Team Meetings to provide more general feedback and to contribute to our improvement activity. The liaison between the QA Team and Independent Reviewing Officer/Independent Chair’s Service has led to better monitoring of Care, Pathway and Child Protection Plans.
- There continues to be a positive link between the Independent Reviewing Officer’s Service and Norfolk In Care Council – researching why children are not attending their LAC Reviews, ensuring young people are involved, as part of a Children/Young People plan at interview for Independent Reviewing Officer’s/Independent Chair’s.
What's is going well

- We have two Independent Reviewing Officer’s undertaking the Birmingham University training for Independent Reviewing Officer’s/Independent Chair’s, who will feedback the knowledge gained to the team to improve our practice and performance.
- We have established a Reviewing Service Web Page for research.
- Independent Chair’s providing training on behalf of the Norfolk Safeguarding Children Board in respect of Multi-Agency Child Protection Conferences; training for newly qualified health visitors; revising and updating induction packs which includes the Signs of Safety documentation; a far greater participation at Local Safeguarding Children's Groups; operational service meetings; and Signs of Safety Depth of Practice meetings.
- As part of the ongoing development and improvement of the service, the Chairing Manager has facilitated a series of workshops designed to improve the quality of Child Protection Plans and to achieve consistency across the county.
- The Chairing Service values feedback from children, young people, parents/carers and professionals, and compliments and complaints received are taken seriously. Between the period of 01.04.15 and 30.09.15, there were two formal complaints made by service users (Mothers) regarding the management of their child’s conference. Both complaints were investigated by the Chairing Manager and the Complaints Team, neither complaint was upheld.
- Since the Signs of Safety model has been in operation, 92% - 97% of feedback received from parents/carers and young people confirm that their experience of the Child Protection Conference process has been positive. This view is also reflected in the feedback forms received from professionals and 95% graded the management of conferences as being consistently Good/Outstanding.
- Parents/carers and young people are fully included in Child Protection Conferences. Their views are shared openly at conference and these are reflected in the Chair’s report. There has been a significant increase in the number of children attending conferences and the referral rate for the Advocacy Service has increased from 50% in 2013/14 to 88% in 2014/15. Service user feedback forms have been specifically designed to ensure that their views are captured and the service continues to improve and develop as a result of the feedback received.
- All children ten years and over will be offered the opportunity to speak to an advocate within the Child Protection process, and are supported to attend conference if they wish to.
- The majority of Child Protection Conferences (99%) happen within timescales.
- Feedback Forms were revised to reflect the Signs of Safety model and scaling questions are now included. The time management of conferences now also forms part of the scaling process.
Voice of Children – What is Going Well?

- IROs help significantly.
- IROs help young people.
- IROs help control Social workers.
- IROs do take control of Social workers, to make them do things.
- "IROs help young people to talk and people to meet their ideas.
- Good that have minds.
- IROs have feedback & plan of action.
- IROs are constants.
- "IROs have got hunter.
- IROs are significant.
- "IROs do listen to young people's thoughts & opinions.
- IROs are easy to get hold of and helped a lot.
- IROs help young people to meet their ideas.
- IROs help for me when things weren't good.
- IROs help to advocate for me when things weren't good.
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The Voice of Children What’s well with IROs.

“My IRO has a sense of humour”.

“They help young people to chair LAC Reviews”.

“Help support young people to talk in meetings”.

“Helped the social worker see things in a more balanced way”.

“Good that have minutes, feedback and plan of action”.

“IRO helped to advocate for me when things weren’t good”.

“IRO’s help young people significantly”.

“My IRO is brilliant. My IRO is fun. My IRO does enough for me. My IRO speaks to me before my review. It’s my choice if I talk to them – that’s a good thing”.

“My IRO has a sense of humour”.

“IRO’s do take control of social workers to make things”.

“IRO’s do listen to young people’s thoughts & opinions”.

“IRO helped to advocate for me when things weren’t good”.

“IRO’s help young people significantly”.

“My IRO is easy to get hold of & helped a lot”.

“They are consistent and in your life a long time”.

“I loved my IRO”.

“They are consistent and in your life a long time”.

“I loved my IRO”.

“Help support young people to talk in meetings”.

“Helped the social worker see things in a more balanced way”.

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“IRO’s help young people significantly”.

“My IRO is easy to get hold of & helped a lot”.

“They are consistent and in your life a long time”.

“I loved my IRO”.
Professionals View on what is Going Well.

“Chair has been brilliant at challenging the family and getting a balanced view of professionals”.

“Very Parent friendly, ensuring mum understood all points”.

“All areas were addressed appropriately and also explored. Chair was considerate to mum’s needs, enabling issues to be explored but acknowledging that mum was finding things difficult”.

“This was well managed under SOS. I believe this to be an outstanding conference”.

“Very clear conference – making it ‘parent friendly’. I like the SOS model”.

“Well managed information, clear, concise and easy for the family to understand. All professionals and family members given adequate time to provide their input”.

“Clear structure, clearly explained, sensitive towards parents, good time management”.
Families View of What is Going Well in Child Protection Conferences.

“We found it opened our eyes on what we were doing right and wrong for the kids safety and wellbeing”.

“The way things were set out on boards made it much easier to understand and have input towards”.

“The plans on the wall were helpful in keeping track on what was going on”.

“I felt really involved with the meeting as an equal rather than a subject”.

“Chair was very good and helped us feel relaxed”.

“Chair was informative and made it an easier experience”.

“I got to speak about what is happening”.

“I found it helpful that an advocate was there to speak for me”.

“Found it helpful knowing that support is going to be on hand if and when needed”.

“Chair was very professional at all times. Very approachable and made me feel at ease instantly”. 
What are we worried about?

- Reducing caseloads in line with recommended numbers has meant that children and young people have been allocated new Independent Reviewing Officer’s, taking away the consistency that they have previously experienced.
- High caseloads in the past year, has impacted on the IRO’s ability to complete the Independent Reviewing Officer/Independent Chair’s report within the 15 working days required.
- Feedback on LAC reviews from service users and professionals still needs to be put in place.
- Low use of advocates for Looked After Children.
- A number of Independent Reviewing Officers have a significant backlog of Chair’s reports, partly due to high caseloads.
- Independent Reviewing Officer’s are not always recording accurately on child’s records to reflect the amount of challenge they do on behalf of the child/young person.
- The emphasis of Independent Reviewing Officer challenge is still on ensuring that basic statutory requirements are met, rather than routinely looking at the quality of work and ensuring that interventions are leading to improved outcomes.
- Independent Reviewing Officer’s have not ensured that all Pathway Plan Needs assessments or Pathway Plans have been completed for relevant children.
- Independent Reviewing Officer’s have not ensured that Looked After Children have meaningful PEP’s.
- The Ofsted Report identified that “IRO’s are not developing consistent relationships with children and young people. They do not sufficiently influence the quality of practice or give enough consideration to permanence for Looked After Children at their second review. The Local Authority’s own Audit (April 2015) identified that Care Plans are not yet specific enough about actions and required progress. In June 2015, 60% of Looked After Children had attended their reviews, although this figure fluctuates and has been as low as 45% in two of the last nine months. More work needs to be done to ensure children and young people are encouraged either by attending or otherwise participating in their review, so that they contribute to their own care planning arrangements.”
- “The level of drive, scrutiny and challenge from IRO’s is not sufficient to ensure that plans progress with pace”. (Ofsted Inspection Report July 2015).
- There are still areas for improvement specifically related to the time management of Child Protection Conferences. In order for the conference process to be more inclusive of family members, the previous 90 minute guide for conferences to be completed was extended to two hours.
- There can be inconsistencies in how the Child Protection Conferences are chaired. This can lead to inequity of outcomes this needs to be reviewed and consistency of practice developed.
- Inconsistency in the expectations of Social Workers and other professionals at conference which can lead to insufficient safety plans being produced with a potential trajectory of poor outcomes for children.
The Voice of Children - What are we Worried About with IROs

What we are worried about?

◉ no private chat between us and the IRO
◉ didn’t know how to talk to me as a young person
◉ previously no information about my IRO (not knowing who the hell they are)
◉ reviews more about you, achievement, changes in your own recovery
◉ IRO have too many young people to look after.
◉ Privacy (Confidentiality) shouldn’t share what we say, wrong to mention.
◉ no time taken to go through after review minutes.

What are we worried about?

◉ IRO for independence (not more)
◉ Don’t push the workers hard enough
◉ Don’t have regular contact
◉ Doesn’t have background information
◉ doesn’t have enough communication with us
◉ Speaks to each other (social) alone without including me
◉ book meetings round their preferences, rather than my
◉ not asking who you’d prefer to come to reviews, makes it uncomfortable for me to see.
The Voice of Children - What are we Worried About with IROs

"I wish my Review was somewhere quieter".

"I'd like the IRO to help me get home to mum sooner".

"No private chat between IRO & YP".

"Previously no information about my IRO (not knowing who the hell they are)".

"IRO have too many young people to look after".

"Didn't know how to talk to me as a YP".

"Reviews more about you, achievement, chairing own review".

"No time taken to go through after review minutes".

"IRO for independence (lot more when new)".

"Don't have regular contact".

"Privacy, confidentiality, shouldn't share what's up or say what is wrong at placement".

"Don't push the workers hard enough".
“Spoke to each other (SW, FC, IRO) alone without including me”.

“Doesn’t have background information, goes of Social Worker opinion and views, rather than YP”.

“Doesn’t have enough communication with YP – speaks to carers more”.

“Book meetings around their preferences rather than the YP”.

“Not asking who you’d prefer to come to review, making it uncomfortable for YP to see”.
What needs to happen next?

- We will prioritise the reduction of caseloads of those few IRO’s whose caseloads exceed 70. We are committed to ensuring all IRO caseloads do not exceed 70, the requirement in the Independent Reviewing Officer Handbook of a caseload.
- Reduction in caseloads will enable Independent Reviewing Officer’s to complete all LAC Review decisions in 5 working days and all Chair’s reports in 15 working days.
- Smaller caseloads will allow Independent Reviewing Officer’s to share their experience and expertise in wider development work and specialisms.
- The Independent Reviewing Officer/Independent Chair’s Service will contribute to the locality audits initially using IRM’s, however as caseloads reduce ensuring IRO’s participate in these audit’s.
- We will increase participation by children/young people and their parents at LAC Review’s by working with In Care Council, Social Work teams and speaking with children and young people.
- We will increase use of advocates for Looked After Children, particularly when issues are placed in Dispute Resolution Process.
- Embedding Locality working. IROS have been formed to work to existing Localities, enabling better working relationships creating a better environment for more effective challenge and mentoring, Healthy positive , challenging relationships need to be encouraged and promoted. This is essential for the promotion of positive outcomes for children and young people.
- “The IRO Footprint” needs to be seen on a child/young person’s file, this will be the evidence of our effective scrutiny and challenge.
- Develop feedback forms for young people, their families, and social worker and partner agencies.
- Independent Reviewing Officer’s need to improve their working relationship with birth families and ensure birth families, where appropriate, take an active part in their child/young person’s LAC Reviews.
- Develop better working relationships with CAFCASS.
- Exemption Reporting BIPS for LAC Reviews out of timescales on a weekly basis, will implement a traffic lights system, to highlight and inform individual Independent Reviewing Officer’s.
- Management Team will implement a Performance Meeting to their Management Meeting schedule. The data will be used to inform all Independent Reviewing Officer/Independent Chair’s in Team Meetings and individual supervision, of areas requiring improvement.
- There will be quarterly reporting from the advocacy lead in respect of use of advocates for LAC.
- There will be responses sent to children and young people following complaints sent to Compliment and Complaints Team.
- Independent Reviewing Officer’s will ensure that the proper matching process is completed on children in Long Term foster placement (achieving permanence Ofsted 2015).
- Independent Reviewing Officer will ensure all Looked After Children have meaningful PEP’s to ensure good educational outcomes.
- Independent Reviewing Officer’s will ensure that children and young people are encouraged either by attending or otherwise participate in their review, so that they contribute to their own care planning arrangements.
- Independent Reviewing Officer’s will ensure that all Looked After Children have a completed Health Assessment within timescales and that the identified needs in the Health Assessment are being met, any delay due to lack of Health resource will be challenged. We will plan to work with the LAC Hub and the Looked After Children’s Nurse, to prevent delay in Health Assessments being completed.
- The Independent Reviewing Officer will check if the Missing From Care procedures have been followed and completed, when notified that a young person has been missing.
- The service has input to fostering support groups.
- Review the implementation of Signs of Safety within LAC Reviews and Conferences and work toward a consistent level of practice across the service.
What needs to happen?

- The Conference process and procedure to be reviewed and for it to reflect what is expected from all professionals and the expectations of the chairs.
- On going review of safety plans being made at conference to ensure they are fit for purpose.
- Disputes to be fully recorded on the child's record to ensure they reflect what has happened and why. Children's views in relation to any disputes should be fully reflected in this recording.
- Regular whole service meetings to reflect changes and developments.
WHAT NEEDS TO HAPPEN

What Needs to Happen?

1. Reports should be UP friendly.
   Reviews should be more about us & our achievements i.e. being more positive.

2. Better choice of time, venue & who attend.
   Make sure UP has made the choice.

3. IRO aware that they are there for UP not foster care and should see UP during.

4. UP chairing their own meetings and being supportive in doing so.

5. Put more pressure on Social workers to make sure deadlines are met.

6. Children's hearings shift to see how easily understood they are.

7. Reviews should be more often, 6 months is too long to wait for a review.
“IRO’s should ask us where their review is”.

“The IRO should make sure we can go home to families where possible”.

“The IRO should ask us when and where the review should be”.

“Reports should be YP friendly”.

“Better choice of time, venue and who attends. Make sure YP has made the choices”.

“Reviews should be more about us and our achievements i.e. being more polite”.

“Put more pressure on social workers to make sure deadlines are met”.

“IRO aware that they are there for the YP and not the foster carers and should see YP before reviews alone”.

“Mystery shopping IRO’s to see how easy contactable they are”.

“Reviews should be more often, 6 months is too long to wait for a review”.

“Better choice of time, venue and who attends. Make sure YP has made the choices”.

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“IRO aware that they are there for the YP and not the foster carers and should see YP before reviews alone”.

“Mystery shopping IRO’s to see how easy contactable they are”.

“Reviews should be more often, 6 months is too long to wait for a review”.

“IRO’s post 18”.

“IRO’s look at improvements over time”.

“Better choice of time, venue and who attends. Make sure YP has made the choices”.

“Reviews should be more about us and our achievements i.e. being more polite”.

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“Mystery shopping IRO’s to see how easy contactable they are”.

“Reviews should be more often, 6 months is too long to wait for a review”.
1. Describing Mandy and her situation then...
End of May 2014 Mandy and her three siblings were placed in foster care and Care Orders granted. Subsequently they were all placed in separate foster placements due to their competing needs. Mandy and her foster carer had been told that Mandy would be in long term foster care due to mum’s inability to parent effectively and reunification was not deemed to be appropriate. After a very short period under 12 months she was told that two of her siblings were returning home and she would follow a few months after her siblings had returned.

2. Her needs were assessed as (or the plan was)... Reunification (although there had not been appropriate or ample work undertaken with mum and children in order for things to be different if she or any of the siblings were returned home). Mandy felt that she had explained to her social worker that this was not what she wanted and that even at contact she could see her mother’s inability to cope with all the children and there was chaos which made her feel scared and anxious about the prospect of having to go home and felt under a lot of pressure by her social worker and by her family.

3. What happened... Mandy spent time with her IRO talking to her about what her anxieties and worries were, and what she felt was working well for her. Mandy was able to be open about what she needed to see change in her mums parenting that would make her feel safe. She was able to be honest about the contact issues and what she wanted to happen in contact with her family which would help to make her feel supported in contact both direct and indirect. Therefore the review explored these areas, and ongoing discussions around Mandy’s wishes and feelings and the need for therapeutic support for Mandy. Mandy doesn’t now feel done to, she feels part of. Her words are that she feels relieved that she is not being forced and feels that she has options and that finally someone was listening, knowing and taking on board what I think! She feels that her IRO explains to her parents what is going to happen, and that she knows at this time going home is not the right thing for her, and her parents know this too. Her third sibling has just returned home to their father and this has evoked lots of contrasting feelings for Mandy. She has many people around her that are supporting her with her difficult feelings, her social worker, foster carer and her parents to some degree, who now understand that returning home for Mandy is not an option at this time.

4. What people said...
IRO said: “Mandy, let’s look at what you want and what some of your worries are about this situation!”

Mandy said: “I need this pressure to stop!”

5. Describing Mandy and her situation now (her outcomes)... Mandy is 12 years old, she remains in foster care where she says she enjoys and wants to remain. She still finds the whole home and foster care issue difficult to manage but is receiving support to help her with her family relationships, the loyalty issues she has between home and foster care and the contact issues – she wants to be able to manage her feelings without feeling guilty, to build relationships and have great contact with her family without feeling the pressure that if she enjoys the contact it will be construed as she wants to return home!

6. What we have learnt from this and can do differently to help others in future (our outcomes)... Mandy says that the different social workers saying different things did not support her with the situation. She felt that her views and opinions hadn’t counted until her LAC Review and then she felt the pressure stopped!
Prior to commencing my new role as an Independent Review Officer next month I have been asked to contribute to their annual report by reflecting upon a case that I was involved in, as a Family Finding Social Worker for the Norfolk Adoption Service, which demonstrates how an IRO and the LAC Review process had helped change the life of a child in the care of the local authority.

Child A (3 year old male) and Child B (2 year old female) were siblings and had been in the same foster care placement since becoming looked after almost 12 months earlier. The children had experienced severe neglect and deprivation whilst living with their birth parents and presented with both physical and developmental delay. It was also mentioned in the children’s Child Permanence Reports that their relationship was minimal. Birth parents had diagnosed learning disabilities and regularity put their own needs before those of the children often leaving the children without supervision for long periods of time. I was allocated as the children’s Family Finding Social Worker after a Placement Order for the siblings had been granted by the court.

The plan was for the children to establish permanence and reside in a safe and secure environment where their needs are able to be met and enhanced.

Although government is very keen for all LAC children to access their free childcare allowance this is not always in their best interests. Each child is an individual, and when a child’s plan is changed to adoption every effort must be made to ensure the placement is successful.

Child A and Child B have been together in their adoptive placement since the summer of 2015 and are awaiting an Adoption Order which will hopefully be granted in March 2016. Both the foster carer and adoptive parents believe the strong attachments forged within the foster placement over the latter part of their placement were key to the smooth transition to their adoptive placement.

Upon attending my first LAC Review for the children it became apparent that the children were not being adequately prepared for their future transition to permanence from the placement, neither adoption or returning to birth family. The eldest sibling, who was described as “demanding” and “a challenge” by the foster carer, and within the CPR, was attending 2 separate nurseries which equated to full time school hours. Whilst his, less mobile and less demanding, sibling was staying at home with the foster carer during the day. The foster carer also commented that he loved nursery and would scream hysterically if he couldn’t attend. The IRO chairing the meeting gave me the opportunity to explain to those present that Child A needed to spend less time at nursery and spend more time establishing a secure attachment to the foster carer. The thought of establishing an attachment was obviously scary for Child A as he had constantly been abandoned by his primary carer in the past. Therefore by spending less time away from his foster carer he was able to keep her at arms length. His current routine may help ‘keep the peace’, however, it wasn’t addressing the issues that needed to be addressed prior to the move to an adoptive placement.

The IRO was very supportive of this argument and recommend that Child A’s nursery provision be reduced in preparation for adoption to establish a transferable attachment between carers.
1. Describing C and his siblings situation then...C and his siblings were accommodated following allegations of physical and emotional abuse whilst at home. C’s family were not living in their country of origin at the time, and C’s racial and cultural background reflects that of his family’s country of origin. C has spent most of his life in the UK with his family. Care Proceedings were initiated and as assessment of C’s parents were undertaken, and C’s siblings returned to the care of members of their family. The assessment concluded that C’s parents were not in a position to provide safe care for C, and he stated that he wanted to remain living with his foster carers, and he did not wish to return to his family.

5. Describing C and his siblings situation now (their outcomes)...A Care Order has now been granted by the Court and C’s parents decided not to oppose the plan for C and there was an early conclusion, which was a relief for C. A matching report is now being completed to endorse the plan for permanence, so C can remain with his foster carers and feel secure about his future. C will have therapy and work is planned to rebuild C’s relationship with his family in the knowledge that he is safe and has a secure base.

2. The needs were assessed as (or the plan was)...C has enjoyed the experience of consistent, safe care whilst in his foster placement and he made it clear that he wanted to remain living with his foster carers. C has made good progress with his education and the foster placement was assessed as meeting C’s care and emotional well-being to a high standard. The Social Work assessment and the Final Evidence that was put before the Court was for C to remain in his placement and for work to be undertaken with C to consider his cultural needs and to build C’s relationships with his wider family.

6. What we have learnt from this and can do differently to help others in future (our outcomes)...C has been given the choice to decide whether he needed an advocate or whether he wanted to advocate for himself. The process was empowering for him and allowed him the opportunity to reflect on what people were saying about his situation. C now knows that he can ask for an advocate at any time, as his situation is complicated and there will be other times he may need to have someone who he can talk to who is independent, and to help him continue to make informed choices for himself. C has decided for himself that he will need the ongoing support of Children’s Services as his situation is so complicated.

3. What happened...C was offered an advocate suggested by his IRO, as the situation was very complicated as all C’s siblings had returned to their family, and C remained very vocal about his wish to remain in his foster placement. It was felt that C would benefit from someone completely independent to help C understand the process and someone to represent his views, without bias. This was explained to C and C considered the offer very carefully and decided that he would represent his views to the Court himself, and this was arranged through C’s Guardian. C did not feel he needed an advocate and he felt enabled to represent himself with the support of his SW and his Guardian.

4. What people said...

“English was not C’s first language and sometimes C would nod and say yes and professionals were worried that he may not have understood the full implications of his situation. They were worried about C’s sense of identity and they wanted to give him every opportunity to make informed choices, whilst acknowledging his wish to live in a nurturing and safe and secure environment, in a community he had spent most of his life in.

“Everybody hoped that should the relationship between C and his family improve and it was considered that the risk of abuse had reduced, it would be possible for C to return to his family’s care one day.”
The statistics below show that throughout the six month period April – September 2015 the number of children subject to Child Protection Plans

<table>
<thead>
<tr>
<th>Month</th>
<th>CP Plans</th>
<th>ICPCs</th>
<th>RCPCS</th>
<th>TOTAL</th>
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</thead>
<tbody>
<tr>
<td>April 2015</td>
<td>615</td>
<td>39</td>
<td>70</td>
<td>109</td>
</tr>
<tr>
<td>May 2015</td>
<td>590</td>
<td>44</td>
<td>86</td>
<td>130</td>
</tr>
<tr>
<td>June 2015</td>
<td>571</td>
<td>42</td>
<td>99</td>
<td>141</td>
</tr>
<tr>
<td>July 2015</td>
<td>551</td>
<td>32</td>
<td>80</td>
<td>112</td>
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<tr>
<td>August 2015</td>
<td>564</td>
<td>23</td>
<td>54</td>
<td>77</td>
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<tr>
<td>September 2015</td>
<td>555</td>
<td>29</td>
<td>77</td>
<td>106</td>
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<tr>
<td>October 2015</td>
<td>448</td>
<td>38</td>
<td>61</td>
<td>99</td>
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<tr>
<td>November</td>
<td>499</td>
<td>44</td>
<td>65</td>
<td>109</td>
</tr>
<tr>
<td>December 2015</td>
<td>478</td>
<td>63</td>
<td>54</td>
<td>117</td>
</tr>
<tr>
<td>January 2016</td>
<td>519</td>
<td>36</td>
<td>81</td>
<td>117</td>
</tr>
<tr>
<td>February 2016</td>
<td>505</td>
<td>30</td>
<td>68</td>
<td>98</td>
</tr>
<tr>
<td>March 2016</td>
<td>484</td>
<td>39</td>
<td>74</td>
<td>113</td>
</tr>
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The reduction in number of children subject to child protection plans during this six month period can be attributed to a number of factors which include: a major restructure of Children’s Services Early Help; an Ofsted inspection; introduction of Signs of Safety; and a review of how risk was being managed across the county.

### Timescales for Child Protection Conferences

Initial and Review child protection conferences have been held consistently within timescale throughout the period 01/04/15 – 30/09/15 as outlined below:

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<thead>
<tr>
<th>Month</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>April 2015</td>
<td>99%</td>
</tr>
<tr>
<td>May 2015</td>
<td>100%</td>
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<tr>
<td>June 2015</td>
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<td>January 2016</td>
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</tr>
<tr>
<td>February 2016</td>
<td>99%</td>
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<tr>
<td>March 2016</td>
<td>100%</td>
</tr>
</tbody>
</table>

In addition, Child Protection Plans and Chair’s reports have been distributed 95% within timescale for this period. The remaining 5% were sent out 5 days later due to sickness absence or unplanned annual leave.
The number of LAC Reviews held from 1st March 2015 to 29th March 2016

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</thead>
<tbody>
<tr>
<td>No. of LAC Reviews</td>
<td>274</td>
<td>239</td>
<td>221</td>
<td>223</td>
<td>255</td>
<td>154</td>
<td>257</td>
<td>287</td>
<td>282</td>
<td>199</td>
<td>195</td>
<td>193</td>
<td>286</td>
<td>3065</td>
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</tr>
</thead>
<tbody>
<tr>
<td>No. of LAC Reviews in Timescale</td>
<td>256</td>
<td>215</td>
<td>202</td>
<td>204</td>
<td>231</td>
<td>127</td>
<td>215</td>
<td>249</td>
<td>231</td>
<td>179</td>
<td>179</td>
<td>185</td>
<td>277</td>
<td>2750</td>
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<tr>
<td>% of LAC Reviews in Timescale</td>
<td>93.4%</td>
<td>90.0%</td>
<td>91.4%</td>
<td>91.5%</td>
<td>90.6%</td>
<td>82.5%</td>
<td>83.7%</td>
<td>86.8%</td>
<td>81.9%</td>
<td>89.9%</td>
<td>91.8%</td>
<td>95.9%</td>
<td>96.9%</td>
<td>88.5%</td>
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The number of LAC reviews held from 1st March 2015 to 31st January 2016 by participation method (excluding children aged under 4 years old)

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>PN1 Child attended and spoke for self</td>
<td>137</td>
<td>104</td>
<td>106</td>
<td>102</td>
<td>119</td>
<td>53</td>
<td>110</td>
<td>125</td>
<td>125</td>
<td>91</td>
<td>75</td>
<td>78</td>
<td>121</td>
<td>1346</td>
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<tr>
<td>PN2 Child attended but advocate spoke for them</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>13</td>
</tr>
<tr>
<td>PN3 Child attended and communicated non-verbally</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>5</td>
<td>2</td>
<td>5</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>PN4 Child attended but did not communicate</td>
<td>1</td>
<td>2</td>
<td>6</td>
<td>1</td>
<td>7</td>
<td>2</td>
<td>9</td>
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<td>2</td>
<td>5</td>
<td>1</td>
<td>45</td>
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<tr>
<td>PN5 Child did not attend but had an advocate</td>
<td>78</td>
<td>64</td>
<td>59</td>
<td>64</td>
<td>65</td>
<td>34</td>
<td>89</td>
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<td>53</td>
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<td>876</td>
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<tr>
<td>PN6 Child did not attend communicated other means</td>
<td>16</td>
<td>23</td>
<td>16</td>
<td>9</td>
<td>14</td>
<td>9</td>
<td>18</td>
<td>17</td>
<td>20</td>
<td>7</td>
<td>6</td>
<td>9</td>
<td>15</td>
<td>179</td>
</tr>
<tr>
<td>PN7 Child did not attend views not communicated</td>
<td>0</td>
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<td>0</td>
<td>4</td>
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<td>6</td>
<td>5</td>
<td>3</td>
<td>2</td>
<td>14</td>
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Invalid participation code

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</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>234</td>
<td>194</td>
<td>188</td>
<td>185</td>
<td>210</td>
<td>100</td>
<td>229</td>
<td>231</td>
<td>240</td>
<td>168</td>
<td>145</td>
<td>148</td>
<td>257</td>
<td>22529</td>
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### LAC Reviews during April 2015 - March 2016

<table>
<thead>
<tr>
<th></th>
<th>PN1 Child attended and spoke for self</th>
<th>PN6 Child did not attend communicated other means</th>
<th>PN1 &amp; PN6 - Involvement in review</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>%</td>
<td>No.</td>
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<tr>
<td>Apr-15</td>
<td>105</td>
<td>43.9%</td>
<td>66</td>
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<tr>
<td>May-15</td>
<td>106</td>
<td>48.0%</td>
<td>60</td>
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<tr>
<td>Jun-15</td>
<td>103</td>
<td>46.0%</td>
<td>66</td>
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<tr>
<td>Jul-15</td>
<td>119</td>
<td>46.7%</td>
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<td>Sep-15</td>
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<td>91</td>
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<tr>
<td>Oct-15</td>
<td>127</td>
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<td>73</td>
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<tr>
<td>Nov-15</td>
<td>126</td>
<td>45.2%</td>
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<td>Dec-15</td>
<td>95</td>
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<td>61</td>
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<tr>
<td>Jan-16</td>
<td>87</td>
<td>39.9%</td>
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<tr>
<td>Feb-16</td>
<td>84</td>
<td>40.8%</td>
<td>57</td>
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<tr>
<td>Mar-16</td>
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<td>43.5%</td>
<td>102</td>
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<tr>
<td><strong>Total</strong></td>
<td>1251</td>
<td>44.0%</td>
<td>845</td>
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INDEPENDENT REVIEWING & CHAIRING SERVICE
TEAM PLAN 2015 – 2016

Working together to keep children safe
<table>
<thead>
<tr>
<th>TEAM OBJECTIVES</th>
<th>Objective Leads &amp; participants</th>
<th>Business Support</th>
<th>By When</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. <strong>Develop an audit process measuring:</strong></td>
<td><strong>Lead: Sally Sinclair</strong></td>
<td>Amanda Cockburn</td>
<td><strong>Ongoing/Review</strong></td>
</tr>
<tr>
<td>- Quality of safety plans between strategy meeting and conference – focused and</td>
<td>**Arlene Hutchens/Ruth</td>
<td></td>
<td>by May 2016</td>
</tr>
<tr>
<td>SMART.</td>
<td><strong>Allerhand/Jenny Sproule</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. <strong>Develop Communication Strategy for IRO/IC/LADOs which includes</strong></td>
<td><strong>Lead: Michael Cox –</strong></td>
<td>Tom Davies</td>
<td><strong>June 2016</strong></td>
</tr>
<tr>
<td>- Mission statement</td>
<td>**Volker Reintjes/Ancil Gerber</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Internal intelligence sharing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- External communication (team presentation, Website)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Develop Locality working alongside operational teams</td>
<td></td>
<td></td>
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<tr>
<td>- Developing effective working relationships, ensuring there is a good system</td>
<td></td>
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<tr>
<td>- for communication and service improvement feedback</td>
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</tr>
<tr>
<td>3. <strong>Develop Engagement Strategy including:</strong></td>
<td><strong>Lead: Michael Cox –</strong></td>
<td>Carolyn Roberts</td>
<td><strong>July 2016</strong></td>
</tr>
<tr>
<td>- Engaging and empowering children and young people; young people in reviews</td>
<td>**Russell Hurn/Tony Warner/Kate Lyon/John Powell/Kim Abel</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Feedback form for LAC reviews</td>
<td><strong>Irene Kerry</strong></td>
<td></td>
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<tr>
<td>- Engaging the NICC</td>
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<td>- Training children/YP to chair own reviews</td>
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<td>- Engaging Birth Families</td>
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<td>- Children and young people’s emotional wellbeing</td>
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<td>- Improve creativity in LAC reviews</td>
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<tr>
<td>4. <strong>Develop action plan for LADO service capacity including:</strong></td>
<td><strong>Lead: Jackie Cole –</strong></td>
<td>Fiona Martin</td>
<td><strong>May 2016</strong></td>
</tr>
<tr>
<td>- LADO cover</td>
<td><strong>Ancil Gerber/Russell Hurn</strong></td>
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<td>- LADO duty</td>
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<td>- Managing Consultations</td>
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<tr>
<td>- Developing S of S</td>
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<td>5. <strong>Improve recording including:</strong></td>
<td><strong>Lead: Michael Cox/Sally Sinclair</strong></td>
<td>Loraine Dunthorne</td>
<td><strong>Draft – May 2016</strong></td>
</tr>
<tr>
<td>- Work with children and young people</td>
<td><strong>Kea Byer/Rachel Kerslake</strong></td>
<td></td>
<td><strong>Final – July 2016</strong></td>
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<tr>
<td>- Improved Dispute Resolution</td>
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<td>- IRO/IC oversight</td>
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<td>- Management Oversight</td>
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<td>6. <strong>Develop staff and service training and development plan including:</strong></td>
<td><strong>Lead: Jackie Cole/Carey Cake/Michael Cox/Sally Sinclair</strong></td>
<td>Angela Woodgate</td>
<td><strong>Ongoing</strong></td>
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<tr>
<td>- Development of S of S</td>
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<td>- Links with good and outstanding authorities</td>
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### Skills Audit
- Link with other LAs using S of S
- Improved legal knowledge and communications with NPlaw
- Quality Assurance role

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<thead>
<tr>
<th>7.</th>
<th>Management oversight to achieve consistency</th>
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<tr>
<td><strong>Monthly Observations of</strong></td>
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<td>LAC reviews</td>
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<td>Child Protection Conferences</td>
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<td>Monthly observations completed by the QA services</td>
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<tr>
<td>Monthly Performance Monitoring Meetings</td>
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<td>Monthly Reflective Practice sessions for all IROs and ICs</td>
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<tr>
<td>Observe Conferences/LAC Reviews</td>
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<tr>
<td><strong>Lead</strong>: Carey Cake</td>
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<tr>
<td>Jackie Cole/Michael Cox/Sally Sinclair</td>
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<tr>
<td>Janette Palmer</td>
<td>Ongoing/Review by 1st May 2016</td>
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<th>8.</th>
<th>Measure the impact of S of S and its implementation into practice.</th>
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<tr>
<td><strong>Audit and Review the implementation of S of S for Child Protection Conference and LAC reviews</strong></td>
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<tr>
<td>Complete observations of all IC’s and IRO’s specifically relating to S of S</td>
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<td>IRO and IC’s to be offered support from an independent S of S coach</td>
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<tr>
<td>Develop a plan including audit tool for the monitoring of S of S practice</td>
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<tr>
<td>Up-date the Process for conferences and LAC reviews in relation to S of S</td>
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<tr>
<td><strong>Lead</strong>: Sally Sinclair</td>
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<tr>
<td>Jackie Cole/Michael Cox/Carey Cake</td>
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<tr>
<td>Angela Woodgate</td>
<td>Ongoing</td>
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<td>June 2016</td>
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‘Working together to keep children safe’

NORFOLK LADO ANNUAL REPORT 1ST APRIL 2015 – 31ST MARCH 2016


It states that each “Local Authority should have designated a particular officer, or team of officers (either as part of a multi-agency arrangement or otherwise to be involved in the management and oversight of allegations against people that work with children”.

Since March 2015, any new appointments to such a role should be qualified social workers.

Norfolk County Council has two fulltime Designated Officers.

The responsibilities of the Local Authority Designated Officer (LADO) are as follows:

- To provide independent and effective management and oversight of allegations relating to individuals employed (paid or unpaid) to work with children and young people.
- Participate in multi-agency training and awareness raising of the role to ensure timely and appropriate referrals.
- To provide support to statutory and non-statutory services in relation to concerns that relate to the conduct of staff that may or may not reach the statutory threshold for the LADO.
- To monitor the progress of cases to ensure that they concluded within agreed timescales, transparent, robust and meet corporate and professional standards.

Data required:

1. Number of referrals

   866 referrals

   395 Tier 1 – Advice and guidance, threshold for LADO involvement not reached.
   233 Tier 2 – Single or multi-agency response – contact from an agency making a referral, but information is not clear enough to determine that the threshold is met.
   201 Tier 3 – LADO Threshold met – evidence that a child had been harmed, evidence to suggest a criminal offence has been committed, evidence to suggest that they are unsuitable to work with children or young people.
   37 Not known
2. Settings

14  Education Employment Agency
185  Education
118  Children’s Homes
82  Early Years
1  Other Local Authority
12  Faith Groups
86  Foster Carers
52  Voluntary
75  Health
7  NCC/Norwich City Council
13  Police
84  Residential Schools
33  Transport
36  Unknown

3. Professional status of alleged perpetrator

9  Administrators (children’s related settings)
7  Cadets
11  Bus Drivers
16  Caretakers
4  Chaperones (Theatre Company / school)
3  Chefs
32  Childminders
9  Church positions
2  Community Trainer (Sports)
2  Counsellors
8  Doctors
6  Early Years Practitioners
1  First Responder Paramedics
7  Football Coaches
83  Foster Carers
2  School Governors
49  Managers
1  Sports Instructor
2 Lecturers
2 Mentors (Schools)
13 Midday Supervisory Assistants
152 Not known
2 Night Workers (Residential)
19 Nurses
1 Parents in position of trust
2 Mental Health Patients in position of trust
1 Petty Officer
1 Photographer
13 Police
1 Hospital Porter
1 Hospital Registrar
32 Residential Child Care Practitioners
1 School Crossing Patrol
5 Scout Leaders
1 Security Guard
7 Social Workers
6 Students
122 Residential Support Workers
2 Swimming Instructors
17 Taxi Drivers
158 Teachers
9 Teaching Assistants
7 Team Leaders (Residential)
18 Therapeutic Care Workers
2 Army Cadets Trainers
3 Youth Workers
11 Waking Night Staff (Residential)

4. Primary cause for concern (where recorded)

37 Complaints
58 Emotional harm
26 Inappropriate electronic communication
23 Indecent images/child pornography
40 Not known
31 Neglect
319  Physical
211  Professional boundaries/conduct
117  Sexual
2  Tragic accident

5. Outcomes (Tier 2 and Tier 3 cases):

- Substantiated 27
- Unsubstantiated 27
- Unfounded 40
- False 17
- Malicious 1
- Unknown 322 – Broken down as 129 administration closures
  193 – Open active cases, which will be waiting for decisions from Police investigations, Court, disciplinary procedures

What's going well?
- Ofsted Inspection Report 2015, noted that the service provided a timely response to concerns and was responsible for chairing strategy discussions for those cases which fell within its remit.
- The quality of minutes and action plans were good and the officers involved were knowledgeable and appropriately questioning and challenging.
- Close partnerships were seen in cases sampled and the designated officers’ role was well embedded (paragraph 47, P18).
- Clear, informative instructions on NSCB website, re the criteria for a referral to the LADO Service.
- Both the LADO referral and consultation forms are on the NSCB website, under how to make a referral (professional’s page).
- Referrals are now only received through written referral rather than telephone calls. This reduces time spent gathering information verbally by the LADO before a decision is made as to whether a referral should be made.
- Random samples of LADO practice observations are undertaken by the three Independent Reviewing Managers.
- The Fostering Allegations Procedures was reviewed and as a result the presence of NCC Foster Carers in the outcomes meeting no longer happens, bringing them in line with all other professionals/individuals subject of an allegation.
- Monthly meetings with Health/Lead Safeguarding Nurse and Designated Doctor.
- Monthly attendance at Safeguarding meetings at both Ellingham Hospital and Huntercombe Hospital, private residential facilities for young people with complex mental health needs. Both hospitals are responsible for looking after a very vulnerable group of young people from all over the country. The monthly Safeguarding meetings at Ellingham Hospital are linked to the LADO role, as the meeting look at those adults, who are in a position of trust, who have harmed or may have harmed children and young people in their care. It’s a private Health Care resource, which provided care for young people under 18 years detained under the Mental Health Act. Catherine Knox, Safeguarding Nurse, also attends.
The Roman Catholic Safeguarding Board, meets 3 times a year, and has representatives from Adult Social Care, Police and Probation. The meeting looks at the progress of cases and investigation relating to priests who have harmed young people/vulnerable adults, whilst officiating as Priests within the church.

Links with other LADO’s via attendance and participation at the Eastern Regional LADO Networking meetings and attendance at the National LADO Conference, Manchester 2014 and London 2015.

Links with the Early Years Senior Management Team has led to improving outcomes for young children in Early Years settings by increasing the understanding of the LADO role.

Participation in the Areas’ LSCB meetings whenever possible

Co-working with Safeguarding and Education has enabled schools to feel more confident in the role of the LADO, evidenced by some of the positive comments received from Heads, who contact the team.

It has also allowed for informal discussions on the more complex cases where a discussion is required as to the “best way forward” for both the young person and adult subject to an allegation.

Working with Human Resources has improved and there is now an on-going dialogue between disciplinary issues and the LADO using the Guidance for Safer Working Practice for Adults who work with children and young people as the framework for discussion.

Reviewing of safeguarding policies and procedures of residential Children’s Homes in order to ensure best and safe practice

Agency Investigation Report format was developed by the LADOs which ensured that clear information about the concerns, and allegations are reported on and ensures that the person of concern has the opportunity to express their views about the allegation against them.

Close working relationships with the MASH (Children's Services and the Police) ensures that cases are dealt with in a timely way and investigations are jointly planned.

Positive feedback from parents and partner agencies about the LADO process indicates that stakeholders overall agree that the service from the LADOs is helpful.

The LADO service ensures that where relevant to the service, the reputational risk for the Local Authority is appropriately managed through an effective ‘Need to know’ procedures being followed.

What are we worried about?

Lack of development and implementation of a bespoke computer system/programme to extrapolate performance. This means performance data and reports relating to performance and activity cannot be easily extracted. Data is currently collated manually which is extremely laborious and time consuming.

The service would be able to: Complete statutory reporting on annual trends on LADO outcomes; Report on outcomes on investigations and what actions were taken; Report on types of allegations; Report on volumes of allegations by employee types and other categorisations; Report on timescales; Lesson learned analysis.

Volume of new referrals means that the LADO does not have sufficient time to close down cases, resulting in a significant backlog of cases waiting to close.

The Norfolk Corporate Programme Office has undertaken a review of the LADO process and efficiency, which highlighted that the LADO Service is needs to have better efficient systems and that the services under resourced by a .5 LADO.

Lack of attendance at LSCG means that the Norfolk LADO is not part of a multi-agency forum where challenges and opportunities to learn from other professionals are available.
• Lack of participation in multi-agency training re: the raising the role of LADO to ensure timely and appropriate referrals.

• Stakeholder evaluations are not being sent to all participants at the end of the process, therefore opportunities to analyse what is working well and what areas of the process need to be improved are being missed.

• Engagement and attendance of key stakeholders can be an issue at times, although use of tele-conferencing has helped.

• A fundamental part of the LADO role is to provide regular performance data to the NSCB so that the board can be assured that the role of the LADO is understood by stakeholders, all statutory and non-statutory agencies.

• A successful communication strategy would enable and inform professionals, agencies and the general public to understand and respond to concerns that they may have in relation to professionals and volunteers.

• Complicating Factors: 1. NCC – development of D.N.A – impacted on LADO – receiving a response to their request for a bespoke data system – First requested November 2013

• 2. Police’s ability to respond in a timely way to cases involving downloading of indecent images of children, which depending on the number of images, can take up to 6 months.

What needs to happen next?

• Further development and implementation of Signs of Safety as part of the LADO process.

• We need to ensure that all referrals proceeding to LADO Multi Agency LADO Meetings (LADO) meet the threshold.

• Implement the recommendations from the Business process review in order to ensure that the service can effectively be delivered

• An effective management information system needs to be implemented which:

  1. Reassures the NSCB and Children’s Services of robust multi-agency engagement in the management of allegations and therefore contribute to the safeguarding of children;

  2. Ensures that agencies receive appropriate support and guidance in cases which do not meet the thresholds;

  3. Ensures that cases do not drift, often cases lasting more than three months are involved in complex disciplinary or criminal proceedings, however agencies involved need to be mindful and be held to account in respect of concluding all investigations in a timely manner.