

**Joint inspection of services to protect children and  
young people in the Aberdeen City Council area**

**November 2008**

<b>Contents</b>	<b>Page</b>
<b>Introduction</b>	<b>1</b>
<b>1. Background</b>	<b>2</b>
<b>2. Key strengths</b>	<b>3</b>
<b>3. How effective is the help children get when they need it?</b>	<b>4</b>
<b>4. How well do services promote public awareness of child protection?</b>	<b>7</b>
<b>5. How good is the delivery of key processes?</b>	<b>8</b>
<b>6. How good is operational management in protecting children and meeting their needs?</b>	<b>12</b>
<b>7. How good is individual and collective leadership?</b>	<b>14</b>
<b>8. How well are children and young people protected and their needs met?</b>	<b>17</b>
<b>9. What happens next?</b>	<b>18</b>
<b>Appendix 1 Indicators of quality</b>	<b>19</b>
<b>How can you contact us?</b>	<b>20</b>

## Introduction

The *Joint Inspection of Children's Services and Inspection of Social Work Services (Scotland) Act 2006*, together with the associated regulations and Code of Practice, provide the legislative framework for the conduct of joint inspections of the provision of services to children. Inspections are conducted within a published framework of quality indicators, '*How well are children and young people protected and their needs met?*'.<sup>1</sup>

Inspection teams include Associate Assessors who are members of staff from services and agencies providing services to children and young people in other Scottish local authority areas.

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<sup>1</sup> '*How well are children and young people protected and their needs met?*'. Self-evaluation using quality indicators, HM Inspectorate of Education 2005.

## 1. Background

The inspection of services to protect children<sup>2</sup> in the Aberdeen City Council area took place between April and May 2008. It covered the range of services and staff working in the area who had a role in protecting children. These included services provided by health, the police, the local authority and the Scottish Children's Reporter Administration (SCRA), as well as those provided by voluntary and independent organisations.

As part of the inspection process, inspectors reviewed practice through reading a sample of files held by services who work to protect children living in the area. Some of the children and families in the sample met and talked to inspectors about the services they had received.

Inspectors visited services that provided help to children and families, and met users of these services. They talked to staff with responsibilities for protecting children across all the key services. This included staff with leadership and operational management responsibilities as well as those working directly with children and families. Inspectors also sampled work that was being done in the area to protect children, by attending meetings and reviews.

As the findings in this report are based on a sample of children and families, inspectors cannot assure the quality of service received by every single child in the area who might need help.

Aberdeen City is situated in the north east of Scotland. It covers an area of 186 square kilometres and is the third largest city in Scotland. It borders with Aberdeenshire Council area.

Aberdeen City has a population of 206,880 with 15.6% of the population under the age of 16 years compared to the Scottish average of 18%. At 2.9% the proportion of the population from a minority ethnic background is higher than the Scottish average of 2%. Unemployment, at around 1.2%, is lower than the Scottish average of 2.5%. Average earnings in Aberdeen City are higher than the Scottish average. During the year ending 31<sup>st</sup> March 2006 482 people sought help for the first time with drug misuse which was higher than most comparator authorities<sup>3</sup>.

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<sup>2</sup> Throughout this document 'children' refers to persons under the age of 18 years as defined in the *Joint Inspection of Children's Services and Inspection of Social Work Services (Scotland) Act 2006*, Section 7(1).

<sup>3</sup> Comparator Authorities include City of Edinburgh, Dundee City, South Ayrshire, Argyll & Bute and Renfrewshire.

## 2. Key strengths

Inspectors found the following key strengths in how well children were protected and their needs met in Aberdeen City.

- The help and support provided by health staff to pregnant women with problem substance misuse.
- The information and advice staff provided to children about keeping themselves safe.
- The involvement of parents and children in decision-making meetings.
- Effective joint working by police and social work staff in the Joint Child Protection Unit (JCPU).

### **3. How effective is the help children get when they need it?**

*Most children knew how to keep themselves safe. A range of services provided effective help and support to vulnerable families. However, these were not always provided quickly enough or for as long as they were needed. Communication between staff who had regular contact with children and families was generally effective. Most staff recognised when children were unsafe and shared their concerns. Children at significant risk were not always seen regularly by staff. The action required to keep them safe was not always taken quickly enough. Children were often left in high risk situations without adequate protection or support.*

#### **Being listened to and respected**

Overall, communication between staff, children and families was satisfactory. Staff across services, including those in the voluntary sector, communicated effectively with children and families and listened to them. Staff used a variety of approaches to help overcome communication difficulties. Not all children and parents with such difficulties had been helped to express their views. Family aids, family centre staff and outreach workers were particularly effective at establishing trusting and supportive relationships with children and families. However, relationships were not always maintained when staff changed frequently, were withdrawn early or when cases remained unallocated within social work. Children were able to express their views to school staff and benefited from trusting and supportive relationships with most teachers, guidance staff and school counsellors. Children benefited from supportive relationships with foster carers and residential workers.

At Children's Hearings panel members encouraged parents and children to give their views and listened to what they said. At these and other decision-making meetings children were supported and sometimes helped to express their views by staff, including family support and outreach workers. *Having your say* forms were not always completed or taken into consideration at Children's Hearings. They were used more often at review meetings for children in residential care where children and families were encouraged to give their views. A children's rights officer helped to ensure that some children in care were able to express their views. Social work staff sent letters to parents before attending Child Protection Case Conferences (CPCCs) inviting them to complete their own report for consideration at the meeting. Parents and children over 12 years of age were encouraged to attend to give their views.

#### **Being helped to keep safe**

Provision of services to keep children safe was satisfactory. Statutory and voluntary services worked well together to provide a range of effective services to support vulnerable children and their parents. However, early intervention services were not delivered in a consistent, targeted and coordinated way across the city. Health visitors, Homestart, and family centre staff provided effective parenting support to parents with young children. Some children benefited from the help they received from outreach support workers. Primrosehill Family Centre, Drugs Action and Family 1<sup>st</sup> worked very well together to ensure a coordinated approach to supporting some substance using parents and their children. The Substance Misuse in Pregnancy Team identified concerns around problem substance in pregnancy at an early stage and provided effective help and support to pregnant women. This support did not extend to other vulnerable women including those experiencing domestic abuse, or who had

learning difficulties or mental health issues. The Young Carers Group provided very effective support to children who were carers within their family. Places were limited and some children were unable to benefit from this support. A specialist health visitor supported effectively homeless families and those who were not registered with a doctor.

Services worked well together to provide opportunities for children to learn about keeping themselves safe. Children took part in a variety of road shows, workshops and education programmes delivered by police, health staff, schools, voluntary and youth organisations. Most children were knowledgeable about the dangers of drugs, alcohol and smoking, and showed a high level of awareness of personal safety. Children received helpful information from foster carers about keeping themselves safe. Schools used *Circle time* to help younger children develop their awareness of keeping safe. Some schools operated a ‘buddy’ system where older children provided support to younger children. Most children were able to identify staff and trusted adults with whom they would share their worries. Procedures for monitoring children missing from education and those being educated at home were not sufficiently robust. There was a high number of vulnerable children excluded from school.

Children had a firm understanding of how to keep themselves safe and healthy. Almost all who responded to school questionnaires and those interviewed by inspectors felt safe and well looked after in school. However, a significant number of children felt that school staff were not always effective at dealing with bullying. Children benefited from their contact with police school liaison officers. Most children were aware of the services provided by ChildLine and how to contact them. Children were aware of the dangers of the Internet, but some were unsure about how to deal with them.

Some examples of what children said about keeping themselves safe:

*“If you use them [internet chat lines] make sure you don’t give them your personal details, and if they harass you then tell your parents.”*

*“Go with a friend to stop bullying.”*

*“Don’t talk to anybody that you don’t know.”*

*“The police come in to school to tell us how to keep safe.”*

### **Immediate response to concerns**

The immediate response to concerns was unsatisfactory. Staff recognised when children were at risk of abuse or neglect and usually reported their concerns immediately. There were some examples of referrals being delayed or not followed up appropriately. Children identified as being at immediate risk of harm were not always protected adequately. When there were high levels of risk to children social work staff relied too heavily on the parent’s agreement to work voluntarily with them. In many cases these arrangements were not effectively reducing the risks to children. Risk assessments placed too much emphasis on how well parents cooperated with staff. Some children who were at significant risk of harm

were sometimes left at home because no safe places were available. Appropriate legal measures to protect them were not always used as the immediate response. In those cases where legal measures were used the conditions imposed to keep children safe were not always fully met. This was sometimes due to the unavailability of safe places. In some instances there were significant delays in reporting cases to the Children's Reporter. This delayed important decisions and action to keep children safe. Children were sometimes placed with relatives or friends without proper background checks and assessments of their suitability being carried out.

### **Meeting needs**

Overall, meeting children's needs was weak. There was a broad range of services to support vulnerable children, but no coordinated and consistent approach to the prioritisation and delivery of services across the city. Many children did not receive the help they needed quickly enough or for as long as they needed it. The needs of vulnerable children were not always fully assessed or clearly identified at decision-making meetings. Some children were left at risk without the help and support they needed. The short term needs of children were met more effectively than their longer term needs. Children did not always receive the support of specialist services quickly enough.

Children and families benefited from a range of services. Richmondhill House provided effective support to a small number of children and families. Family centre staff, Drugs Action and Family 1<sup>st</sup> helped parents with problem substance misuse and their children. Child development centres supported children with additional health needs. Young people experiencing difficulties with drugs or alcohol were helped by specialist health staff and the Substance Misuse Team. Some children who were at risk or looked after did not receive regular contact or help from their social worker. When children's names were removed from the Child Protection Register (CPR) the help and support was often withdrawn immediately or too quickly. A shortage of local foster care and residential placements meant that a number of children had to be looked after further away from their home. Young people leaving care and those returning from care outwith the area did not always have access to supported accommodation.

Children's mental health services provided effective help for children with emotional and psychological difficulties, but they often had to wait a long time before being seen. Counsellors and primary mental health workers helped and supported children in some schools. The Corrieneuchin and SALUS services provided effective help to children who had experienced sexual abuse or were displaying sexually harmful behaviour, but places were limited. Some children did not get this type of help quickly enough. Women's Aid supported women and children experiencing domestic abuse, but they had insufficient resources to provide wider support specifically for children.



#### **4. How well do services promote public awareness of child protection?**

*Services had produced helpful materials about child protection, but these were not made easily available to the public. Some services provided helpful information about child protection on their websites. Members of the public reported concerns about children to services. A more coordinated approach to raising public awareness was required.*

##### **Being aware of protecting children**

The promotion of public awareness was satisfactory. The North East Scotland Child Protection Committee (NESCPC) and individual services had produced a wide range of child protection information leaflets and posters. Some of these were available in other languages. However, they were not always prominently displayed in public offices. The Grampian Police website contained very good information on child protection which could be accessed easily. The NESCPC had established a working group to improve its website. The NHS Grampian website had no helpful information about child protection. The Aberdeen City Council website provided a contact telephone number of social work services but did not provide user friendly or easily accessible information about child protection. Grampian Police had raised public awareness through local radio. There had been no coordinated approach across services to raising public awareness of child protection.

Recent child protection referrals from members of the public had been made using the National Child Protection Line. These were passed to the out-of-hours social work service. Members of the public contacted police and social work services when they had concerns about children's safety. Police and social work staff dealt with most of these concerns, including anonymous referrals, promptly and appropriately. Occasionally, members of the public passed their concerns about vulnerable children directly to the Children's Reporter. Specialist police family protection officers and staff in the social work duty teams were available during office hours. The police force control room and service centre, together with the out-of-hours social work service, ensured that appropriate staff could be contacted at any time. Staff from other services were sometimes unsure about which social work centre to contact to pass on information or concerns about vulnerable children.

## 5. How good is the delivery of key processes?

*Parents and children were encouraged to attend decision-making meetings. Children and parents were not always helped to prepare for meetings. Chairs of meetings ensured that they were fully involved and understood what was happening. There were weaknesses in approaches to sharing information. In some services there was poor recording of information in case records. There were significant weaknesses in the assessment of risk, including delays which resulted in children being left in situations of considerable risk. Core group meetings to monitor and review child protection plans were not always held or held regularly enough. These meetings and review Child Protection Case Conferences (CPCCs) were often poorly attended by staff.*

### **Involving children and their families**

The involvement of children and families in key processes was satisfactory. Parents were routinely invited to CPCCs and child care reviews. Depending on their age and circumstances, children were invited to attend all or part of decision-making meetings. Foster carers were not always invited. Family centre staff discussed their reports with children and families and helped them to prepare for meetings. Social work reports consistently recorded the children's and parent's views, but these were not always shared with them before meetings. Some children and families were not helped by social work staff to prepare for meetings. Health and education reports were rarely shared with the children or families in advance of meetings. Chairs helpfully explained procedures to children and families before meetings started and ensured that they understood what was going to happen. They also ensured that children and families had seen and understood key reports. Children and families were encouraged to contribute to the development of care plans. Stressful or distressing situations were dealt with effectively. Families were anxious and suspicious about private meetings between staff which preceded almost all CPCCs. These were held to enable staff to share confidential information, but much of that information could have been shared with children and families in the open meeting. Guidance had been issued recently to ensure that staff were aware of the information that should be shared more openly with children and families or withheld from them. The minute and decisions of meetings were sent to children and families. However, families were not always clear about decisions and what was recorded or expected of them. Some children and families had been told that there was no appeal against decisions of CPCCs. Advocacy services were not available to all children and parents who needed them.

All services had clear and effective policies and procedures for dealing with complaints. The social work procedures were still in draft form. Information on how to make a complaint was available on websites and in leaflet form. The social work service had developed helpful information leaflets specifically aimed at children and these were widely available. The service had effective systems for managing and tracking the progress of complaints. However, parents and children were not always clear about the level of service they should expect. Some parents did not know how to make a complaint when they were dissatisfied with the service.

## Sharing and recording information

The sharing and recording of information was weak. Staff in all services were aware of the need to share information and of its importance in protecting children. A Pan-Grampian information-sharing arrangement was in place but had yet to be fully used. There were good local, professional relationships and trust among staff in key services which contributed greatly to information-sharing. However, too much emphasis was placed on informal approaches. Multi-agency meetings brought staff together to share information but attendance and frequency of meetings were inconsistent. When meetings took place there was usually appropriate sharing of relevant information.

Particular features of information-sharing included the following.

- Good information-sharing among key services at CPCC and core group meetings.
- Improved information-sharing by substance misuse services with social work staff, the Reporter and at case conferences.
- Effective information-sharing and communication about vulnerable children in and across health services.
- Feedback to staff who made child protection referrals to the police and social work was not always provided or recorded.
- Important information was not always shared, for example, information about the health or domestic circumstances of children was not shared with schools.
- Housing services were not involved routinely in sharing information about child protection.
- Information-sharing was not always seen as a shared responsibility, with some services being reluctant to take the lead.
- Insufficient information recorded electronically by social work staff caused difficulties for other staff who accessed the system, including out-of-hours staff.

Recording in children's files was inconsistent. Social work files were well structured and contained a dated list of family events and staff involvement, but not all significant events in the child's life were recorded. Records of case discussions and core group meetings were often missing. Records of supervision and monitoring of case practice were inconsistent. Health and social work records had gaps in contact notes, with little recorded about direct work undertaken with children and families. School files were not structured well. School and health files contained no reference to the child's care plan.

Staff were aware of the need to obtain consent from children and families to share information. They were also aware of the need to inform them of what information had been shared and with whom. Staff recognised the need to inform service users about information shared despite consent not being given. However, staff did not always fully understand the need to share confidential information. Practice in sharing confidential information, seeking consent of children and parents and informing them of what information was to be shared was inconsistent across services. Consent and the information shared were not routinely recorded in children's records.

Police, criminal justice social work and housing staff routinely shared information regarding risks posed to children by sex offenders. There were good links between staff involved in managing sex offenders and the police family protection unit. Staff managing sex offenders attended CPCCs where there was a sex offender issue. Children and families' social workers

were invited to participate in joint risk assessments of sex offenders where child protection was a consideration. However, they did not always share information at formal meetings. They did not always attend meetings or provide information on time.

### **Recognising and assessing risks and needs**

Overall, recognising and assessing risks and needs was unsatisfactory. Most staff recognised when children needed help or were at risk and reported their concerns appropriately. Occasionally, concerns were not reported or investigated immediately. Most concerns were channelled through the JCPU ensuring consistency of approach. Police and social work staff in the JCPU worked well together and responded effectively to concerns. Staff gathered information from health and schools and carried out an early discussion and assessment of referrals. This Initial Referral Discussion (IRD) was recorded and decisions about how to proceed were agreed. Most IRDs involved police, health and social work staff. Staff in the JCPU considered all other police referrals and decided on the most appropriate course of action. Health and education staff were not involved in making this assessment. Relevant information was not always shared with them. Children's Reporters were unclear about how these decisions were made. There were inconsistencies in referrals made to the Reporter and in the Reporter's response to them. There were instances of concerns about children and families not being assessed or followed up adequately by social work staff. Sometimes there were delays between the completion of an investigation and the initial CPCC being held.

CPCCs were held regularly. The risk assessments at these meetings were almost always based on the social worker's report. The assessments were suitably structured, but lacked rigour. There was no consistent approach to risk assessment within social work. Many staff were not familiar with the Council's risk assessment framework. They decided for themselves whether or not to use it. Most risk assessments relied too heavily on individual workers' personal opinions and experiences with little analysis of risk. Too much reliance was placed on parental cooperation. There were delays in submission of social work reports to the Children's Reporter and delays in decision-making by the Reporter. The provision of insufficient information contributed to delays. Children were often left in situations of risk until decisions were made. Children on the CPR did not always have an allocated social worker and it was unclear who was assessing progress against identified risks. In many cases the services did not intervene quickly enough, particularly in cases involving parental substance misuse and neglect. It was only when crisis point had been reached that effective action was taken. As a result, children were placed or left in high risk situations.

The approach to joint child protection investigations carried out by police and social work was inconsistent. Police and social workers undertaking interviews with child victims had not always completed the relevant training. Additional training opportunities were being provided. Statements noted during interviews were not always shared with social work staff and filed appropriately. Medical examinations were conducted by experienced paediatricians and police surgeons in a child friendly environment in Aberdeen Children's Hospital. Joint medical examinations by paediatricians and police surgeons were only performed in cases of sexual abuse. Some older children were examined in police premises by police surgeons only. In these circumstances their wider health needs may be overlooked.

Staff were alert to the risks to children of parents misusing drugs or alcohol. Health staff worked together to assess and coordinate support for pregnant women with problem substance misuse. An effective multi-disciplinary approach to assessing the risk and needs of

children affected by parental substance misuse had not yet been established. Revised “*Getting Our Priorities Right*” guidelines had only recently been introduced. There were delays in completing risk assessments of pregnant women and in holding pre-birth child protection cases conferences. In some cases the meetings were not held until after the child’s birth. Risks to unborn babies were not always properly assessed.

### **Planning to meet needs**

Overall, planning to meet children’s needs was unsatisfactory. Child protection plans were not specific enough and were not always fully implemented. They were not monitored or reviewed well enough by staff to take account of changing circumstances. Children on the CPR or in care did not always have an allocated social worker which reduced the effectiveness of planning. Decisions made at some CPCCs and by the Children’s Reporter did not always reflect the level of risk to children. Children were often left in situations of risk. There were significant delays in planning for the longer terms needs of vulnerable children.

Most CPCCs and child care reviews were held promptly. The decisions and minutes of these were usually circulated in good time. Most initial CPCCs were well attended. Review case conferences, where important decisions based on risk assessment were taken, including decisions about de-registration were not well attended. The quality of child protection plans was variable. They did not have clear aims or timescales. A lead professional responsible for progressing actions was not always identified. Often plans, including those made prior to de-registration, were not fully implemented to reduce risk and effect change. Some children remained on the CPR for too long without their situation improving. Others had their names removed from the register without a full assessment being completed or prematurely on the assumption that a supervision requirement would be granted. Independent chairs were not given sufficient authority to effectively challenge lack of progress of plans or decisions where they considered children to be at significant risk.

Planning meetings for children on the CPR and those in care were held separately. Parents and children were sometimes confused by this. There were delays in progressing plans for children to be placed permanently with new families. The poor quality of social work reports and the time taken to complete them contributed to these delays and delays in holding children’s hearings. When the plan was for the child to return home and sufficient progress was not being made or sustained by parents, staff were slow to react and revise the plan. The lack of alternative care placements made effective planning more difficult.

There was no consistent approach to the monitoring and reviewing of child protection plans for children on the CPR. There was no guidance or procedures in place on this. In many cases core groups were not held regularly or at all. Staff and managers were unclear about the purpose of core groups and of their responsibilities to implement them. Most children on the CPR did not have their protection plans reviewed, even when their circumstances changed. Changes were sometimes made to plans by social workers without the agreement of other services. This had left a number of children at risk.

**6. How good is operational management in protecting children and meeting their needs?**

*Policies and procedures were available to guide staff in their work, but some were either missing, not up to date or not easily accessible. There had been no collective approach taken to developing integrated children’s services and progress was limited. Management information about the effectiveness of services and key child protection processes was not readily available. Within and across services little had been done to ensure that vulnerable children and families were involved in policy development and planning. There had been no collective approach to address significant staffing issues in some services, particularly social work. Not all staff had received the training they required.*

Aspect	Comments
Policies and procedures	Policies and procedures were weak. Individual services had a range of policies and procedures to guide their work in protecting children, but some staff could not access them easily. Some key policies and procedures were missing, for example, those relating to children in care and homelessness. Some policies required updating to reflect current practice. The NESCP inter-agency guidelines provided advice for joint-working. Policies and procedures for staff did not always reflect these. There were major weaknesses in the management, dissemination, evaluation and updating of policies. As a result of this the impact of policies on practice was not fully known.
Operational planning	Operational planning was weak. The Integrated Children’s Service Plan – “For Aberdeen’s Children” (ICSP) outlined improvement objectives. Key stakeholders, including police and housing, had not been involved effectively in its development. The health service had become more actively involved in the development of a new plan. Operational managers were not accountable for delivering actions identified in the plan within agreed timescales. Staff did not understand their role in implementing it. Progress reports were produced, but they did not show how vulnerable children’s lives had improved. Structures were developing to implement and monitor the ICSP at a local level. Management information across services to inform planning was insufficient. There had been no coordinated approach to developing robust management information. The NESCP did not have sufficient information from which to evaluate the effectiveness of key child protection processes. Management information available to staff who chair CPCCs was not being used by senior managers.

<b>Aspect</b>	<b>Comments</b>
Participation of children, their families and other relevant people in policy development	Overall, the participation of children and families in policy development was unsatisfactory. Some individual staff and services, including the JCPU, had begun to seek information from service users to help develop and redesign services. Senior managers within Aberdeen City Council had gathered children's views through Dialogue Youth, Children 1 <sup>st</sup> and at special events. However, children had not been involved effectively in the development of the ICSP. Across services approaches to involve vulnerable children and families in policy development and planning were not well established. This had been identified by the NESCCPC.
Recruitment and retention of staff	Overall, recruitment and retention of staff was weak. A collective approach had not been taken to identify and address staff shortages, particularly in social work. Social work staff were not always sufficiently experienced to undertake complex child protection work. Many social workers had very high caseloads. The child mental health and disability services faced pressures in meeting levels of demand for help and support. All services had carried out enhanced disclosure checks on newly appointed staff who were involved in direct work with children. All services had effective procedures for investigating alleged abuse by staff members and foster carers.
Development of staff	The development of staff was weak. Individual services provided child protection training for most staff. Opportunities to undertake inter-agency training were limited by the availability of places. The provision of inter-agency training did not meet the needs of some senior and more experienced staff. Staff in health and social work had not always received the training they required. Insufficient training was available for police and social work staff required to conduct joint interviews with children. There was no training strategy or monitoring of the impact of training on practice. Monitoring and reviewing the work of staff in some services was inconsistent.

## 7. How good is individual and collective leadership?

*Individually and collectively services had developed a vision for protecting children. Within the local authority this had not been communicated effectively. Chief Officers, The North East Scotland Child Protection Committee (NESCPC) and senior managers within the local authority did not have a clear view of the effectiveness of child protection services. There were important weaknesses in their leadership and direction. Partnership working was not firmly established within the local authority. Across services there was scope for improvement. Some services had reviewed their own practices and identified areas for improvement. An approach to self-evaluation and quality assurance had not yet been established across services.*

### **Vision, values and aims**

Overall, the vision, values and aims to protect children was weak. Individually services had established a vision, values and aims for keeping children safe. Senior managers and leaders were generally clear about their individual and collective responsibilities.

- Elected members were clear about their individual and collective responsibilities. The Chief Executive had a vision for child protection, but not all Corporate Directors had a clear understanding of it. The corporate vision had not been communicated effectively to operational managers and staff. They were unclear about the Council's aims and objectives for child protection.
- Senior managers within NHS Grampian had a clear vision for the protection of children in Aberdeen. Child protection was recognised as a key priority within hospital, specialist and community health services. Staff were aware of their responsibilities and of the importance of keeping children safe and healthy.
- The Chief Constable had a clear vision for child protection which was shared by his senior officers. Child protection was a key strategic priority for Grampian Police. This had been communicated effectively to staff at all levels who were clear about their individual and collective responsibilities for the safety and welfare of children.

The ICSP 2005-2008 set out a shared vision “*For Aberdeen's Children*”, but not all services had been involved in developing it. Across services there was a low level of awareness and understanding of the ICSP among operational managers and staff, and how it influenced their work. It had not been communicated effectively. It was not regarded as a key document for delivering change and improvement.

### **Leadership and direction**

Overall, collective leadership and direction was weak. Within the police and health services clear lines of accountability for child protection had been set. Chief Officers and senior managers were clear about their collective responsibility for protecting children. The Chief Executive Officers Group provided strategic oversight of the NESCPC which was chaired by the Chief Constable. There was a strong commitment to partnership working. However, Chief Officers and the NESCPC did not have a sufficiently clear strategic overview of the effectiveness of child protection services in Aberdeen. They did not have robust performance management information about key child protection processes.



The NESCPCC had been re-structured in 2005 and was jointly funded. The Chief Constable had provided strong and effective leadership and direction in establishing its strategic planning framework. Progress had been made in developing updated inter-agency child protection guidelines and a process for significant case review. Progress had been slower in others areas, for example in training. Aberdeen City Child Protection Practice Group had not been operating effectively and its link to the NESCPCC was not fully understood by managers and staff. It had been recently reformed as the Aberdeen City Child Protection Sub-Committee.

Within the local authority there was a lack of leadership and direction of child protection and social work staff. There was poor communication between Corporate Directors, managers and staff and strained relationships. Lines of accountability were not always clear to staff. Strategic managers were not sufficiently aware of serious weaknesses in social work practice which had resulted in some children being left unprotected in high risk situations. Across services, no collective approach had been taken to improve assessment and planning for vulnerable children.

### **Leadership of people and partnerships**

Individual and collective leadership of people and partnerships was weak. Within the Council, joint-working to protect children was not established across all services. Staff in other services did not always understand the Council's structure and were often unclear about who to contact. Their work was sometimes duplicated by having to meet with Council staff from each neighbourhood. The separation between strategic and operational management created barriers to matching needs with services and joint decision-making. A range of voluntary services benefited vulnerable children and families, but cutbacks and uncertainty about funding had reduced their effectiveness.

There was strong partnership working between police and social work staff in the JCPU. They worked effectively together with hospital staff. This dynamic arrangement was generating continuous improvements in practice. The police and the Council joint funded three campus police officers who were providing effective help and support to children in schools. Integrated community based mental health services for children had not been developed as planned. Partnership working to meet the needs of vulnerable children was in the early stages of development in neighbourhoods and local communities. Insufficient importance had been given to building trust and confidence among children's reporters, panel members and other staff.

Health and Council managers were seeking to re-design services for vulnerable children, but joint planning was being hampered by the Council's financial difficulties. Services had not worked effectively together to develop services for children affected by substance misuse. The response to children living with adults misusing drugs and alcohol was not coordinated well enough. Inter-agency procedures that had been agreed were not established in practice. Services for substance misusing mothers and their partners were not effectively reducing the risk to babies prior to birth. Services for pregnant women affected by mental illness and learning disability had yet to be developed.

## **Leadership of change and improvement**

Leadership of change and improvement was weak. Some individual services had reviewed their practice and made improvements. Across services no collective approach had been taken to structured self-evaluation. A procedure for significant case reviews had been agreed and two reviews completed. There had been varying levels of commitment to this process from partners, leading to delays. Learning from these reviews had not been communicated effectively to staff. There was no evidence of improvements in practice. Action to address the findings of a case file audit carried out in 2006, which identified significant delays in the Children's Reporter's decision-making, had not yet been fully effective.

The NESPC had delivered some improvements for example, in producing updated inter-agency guidelines. The police had carried out a review of their Family Protection Units (FPUs). An action plan had been produced and significant improvements achieved. Plans for the JCPU to move to larger premises had been agreed. The Chief Constable was determined to maximise the benefits of joint-working. The police were leading on exploring opportunities to include health and education staff within this facility and relocate the out of hour's social work service. The JCPU and the social work quality assurance team had consulted with service users. Feedback was informing improvement plans.

The Chief Social Work Officer led an audit of their child protection case files which was completed in December 2007. Although significant areas for improvement were identified, effective action to address them had not yet been taken. Health and social work managers did not routinely audit case files of vulnerable children. Health visitors and school nurses had carried out internal reviews of key processes and audited case files. However, resulting improvements in practice and outcomes for children were unclear. There was limited performance reporting on child protection within health services.

## **8. How well are children and young people protected and their needs met?**

### **Summary**

Inspectors were not confident that all children at risk of harm, abuse or neglect, and in need of protection, were receiving the help and support they needed. Inspectors were particularly concerned about the numbers of children living in high risk situations with drug abusing parents without adequate support or protection. In many cases effective action was not taken until crisis point had been reached. When there were high levels of risk there was an over-reliance by social work staff on working voluntarily with parents. The appropriateness of these arrangements had not always been properly assessed. Appropriate legal measures were not used even in some of the most serious and high risk cases. Work was required urgently to provide staff with clear guidance, policies and procedures to improve the assessment of risk to children and to ensure that staff used these consistently.

The NESCP and the individual services they represent, guided by Chief Officers should ensure that they make improvements to strengthen services to protect children in Aberdeen. In doing so they should take account of the need to:

- ensure safe alternative care arrangements are provided for all children identified as living in situations which are unsafe, using appropriate legal measures when necessary;
- improve information-sharing and recording;
- improve assessments of risk and needs;
- improve joint planning to meet children's needs, ensuring that child protection plans are implemented, regularly monitored and reviewed;
- develop a systematic approach to gathering the views of children and families about services and use these to make improvements;
- ensure sufficient levels of staff within the children and families social work service; and
- ensure that Chief Officers monitor the effectiveness of the NESCP and key child protection processes to better protect children and meet their needs.

## **9. What happens next?**

The Chief Officers have been asked to prepare an action plan indicating how they will address the main recommendations of this report, and to share that plan with stakeholders. Within four months Chief Officers should submit to HM Inspectors a report on the extent to which they have made progress in implementing the action plan. Within one year of the publication of the report HM Inspectors will re-visit the authority area to assess and report on progress made in meeting the recommendations.

**Kevin Mitchell**  
**Inspector**  
**November 2008**

## Appendix 1 Quality Indicators

The following quality indicators have been used in the inspection process to evaluate the overall effectiveness of services to protect children and meet their needs.

<b>How effective is the help children get when they need it?</b>	
Children are listened to, understood and respected	Satisfactory
Children benefit from strategies to minimise harm	Satisfactory
Children are helped by the actions taken in immediate response to concerns	Unsatisfactory
Children's needs are met	Weak
<b>How well do services promote public awareness of child protection?</b>	
Public awareness of the safety and protection of children	Satisfactory
<b>How good is the delivery of key processes?</b>	
Involving children and their families in key processes	Satisfactory
Information-sharing and recording	Weak
Recognising and assessing risks and needs	Unsatisfactory
Effectiveness of planning to meet needs	Unsatisfactory
<b>How good is operational management in protecting children and meeting their needs?</b>	
Policies and procedures	Weak
Operational planning	Weak
Participation of children, families and other relevant people in policy development	Unsatisfactory
Recruitment and retention of staff	Weak
Development of staff	Weak
<b>How good is individual and collective leadership?</b>	
Vision, values and aims	Weak
Leadership and direction	Weak
Leadership of people and partnerships	Weak
Leadership of change and improvement	Weak

This report uses the following word scale to make clear the evaluations made by inspectors:

Excellent	Outstanding, sector leading
Very Good	Major strengths
Good	Important strengths with areas for improvement
Satisfactory	Strengths just outweigh weaknesses
Weak	Important weaknesses
Unsatisfactory	Major weaknesses

## **How can you contact us?**

### **If you would like an additional copy of this report**

Copies of this report have been sent to the Chief Executives of the local authority and Health Board, Chief Constable, Authority and Principal Reporter, Members of the Scottish Parliament, and other relevant individuals and agencies. Subject to availability, further copies may be obtained free of charge from HM Inspectorate of Education, First Floor, Denholm House, Almondvale Business Park, Almondvale Way, Livingston EH54 6GA or by telephoning 01506 600262. Copies are also available on our website [www.hmie.gov.uk](http://www.hmie.gov.uk)

### **If you wish to comment about this inspection**

Should you wish to comment on any aspect of child protection inspections you should write in the first instance to Neil McKechnie, HMCI, Directorate 6: Services for Children at HM Inspectorate of Education, Denholm House, Almondvale Business Park, Almondvale Way, Livingston EH54 6GA.

### **Our complaints procedure**

If you have a concern about this report, you should write in the first instance to our Complaints Manager, HMIE Business Management Unit, Second Floor, Denholm House, Almondvale Business Park, Almondvale Way, Livingston, EH54 6GA. You can also e-mail [HMIEComplaints@hmie.gsi.gov.uk](mailto:HMIEComplaints@hmie.gsi.gov.uk). A copy of our complaints procedure is available from this office, by telephoning 01506 600200 or from our website at [www.hmie.gov.uk](http://www.hmie.gov.uk).

If you are not satisfied with the action we have taken at the end of our complaints procedure, you can raise your complaint with the Scottish Public Services Ombudsman (SPSO). The SPSO is fully independent and has powers to investigate complaints about Government departments and agencies. You should write to the SPSO, Freepost EH641, Edinburgh EH3 0BR. You can also telephone 0800 377 7330 (fax 0800 377 7331) or e-mail: [ask@spsso.org.uk](mailto:ask@spsso.org.uk). More information about the Ombudsman's office can be obtained from the website: [www.spsso.org.uk](http://www.spsso.org.uk).

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