

LEWISHAM
Recording Guidance
for
Children Social Care
Staff

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To be included into this chapter when re-drafted: Managers and supervisors should have an oversight of the recordings of their supervisees and make a note on the file that they have read the file. Decisions made on a case should also be recorded by the manager / supervisor. Files and recordings should be checked and signed off by the manager / supervisor before the transfer or closure of a case.

Introduction

Record keeping is a cornerstone of good social work practice. Records serve a variety of important purposes. Bearing these in mind when recording helps practitioners ensure records are useful and that appropriate information is recorded.

Key Functions of Recording

- Full and detailed information is available about families' needs and the success of past interventions. This can be used to guide future work.
- When social workers record objective information about a case (separately from their analysis and views) managers can use this to inform their own views about what intervention is indicated. Social workers vary in their aversion to risk and managers can help restore balance.
- In the case of an allocated worker being unavailable colleagues are able to obtain information about a case including information regarding any risks to children and can then use this information to effectively work on the case.
- Records provide evidence of work undertaken, decisions made and the rationale for those decisions. Records can help demonstrate that expected standards of social work have been met.
- Children may choose to view their records when they are older and this may help them make sense of events that have taken place in their lives and understand the rationale for Social Services intervention.
- Records provide information and data that the Borough can use to evaluate its performance.

Certain records, for example assessments and reviews, should generally be shared with clients. Clients are entitled to view their file and may request this. Records may be scrutinised by management in case audits and records may be shared with the Courts. The practitioner should be constantly aware when recording that what they write may be viewed by others. Clarity and writing about service users in a respectful way is critical.

This guidance begins with some general pointers regarding good recording. Advice regarding recording is then set out with reference to the Assessment System, looking specifically at recording on dairy and contact sheets, meeting

records and assessments. The section on assessments contains guidance regarding difference and diversity issues. Guidance is given regarding what information should be recorded in supervised contact reports and regarding how to record legal advice.. Lastly, standards for recording data are given, including what data should be recorded, timescales for this recording, and details of which documents require management authorisation. Examples of good and poor recording practice are included as appendices where names have been anonymised. The final appendix is a summary of recording do's and don'ts.

This guidance should be read in conjunction with data protection legislation available on the intranet.

References:

Department of Health (1999) *Working Together to Safeguard Children*. Department of Health, London.

Department of Health (2000) *Framework for the Assessment of Children in Need and their Families*. Department of Health, London.

Laming H (2003) *The Victoria Climbié Inquiry*. www.victoria-climbié-inquiry.org.uk

Walker S, Shemmings D and Cleaver H *Write Enough; Effective Recording in Children's Services* www.writeenough.org.uk

General Recording Guidance

Keep records up to date

It is important to record quickly after the event both to ensure that all relevant information is on the case file if the social worker is absent, and because the sooner recording is undertaken after the event the more likely the worker is to remember key information.

To facilitate this it is important to allocate time to record when there will be minimal interruptions and to record as you go along to avoid accumulating lots of outstanding write-ups. It can be useful when planning a significant contact with a family or individual to include recording as part of your time allocation.

Ensure the child is present in the record

Crucial in terms of safeguard children's welfare is that information is recorded regarding children's behaviour and emotional well-being and information about their views wishes and feelings and that consideration is given to this information.

It is necessary for the practitioner to spend time alone with children when undertaking assessments and monitoring plans. Sessions to elicit information about the child's world should be planned to meet the needs and abilities of the individual child. It is necessary to raise with the child difficult issues that affect the child so that the practitioner has a better sense of the child's experiences in relation to these things.

Children are not necessarily able to articulate in words their wishes and feelings or information about what they are experiencing. It is necessary for the social worker to record what the child says, but also for the social worker to state what the child's behaviour, what they say, and their interaction with their parent(s)/carer(s) indicates about their emotional well-being and the care they are receiving.

When assessment and casework is undertaken parents needs can dominate at the expense of the child. It is critical that time is spent with the child and information about the impact of the parent's problems on the child is recorded.

Distinguish between facts and professional judgement

The first stage of the social work assessment is gathering information and this information should be set out in the assessment. Opinions of professionals and the family should be recorded as opinions and not as fact.

Following the information gathering stage the social worker should record their professional judgements, views and analysis that will be based on the information collected and also research and their own experience. It is crucial

this analysis is present as otherwise all that is recorded is facts / description. It is necessary to record why things may be happening and the rationale underpinning decision making. The social worker should make clear these views are not fact but their opinions and they should be substantiated with supporting information so managers can follow or test the conclusions arrived at.

The record should be clear and concise

The record should allow someone who is not familiar with the case to easily locate key information and patterns in the child's life. (Chronologies are very important in relation to this and should be attached to each case file). Reports such as assessments and reviews and meeting reports should be focused and concise. Cutting and pasting from other documents should be avoided.

Records of contact with families should not be narrative and should only be descriptive if this is necessary to illustrate something important. Otherwise these should be clear and concise and outline the relevant information obtained. Bullet points can be helpful.

It is necessary for records to contain information about contact with families and professionals and information about a family's needs and action undertaken by the agency. However, information should be focused and excessive and defensive recording is unhelpful and inefficient. It is necessary for the social worker to use their professional judgement when deciding what to record and what to leave out. Supervision discussions and research can be helpful in assisting identifying significant information, as can ensuring there is a clear plan for each case and using this to structure intervention and recording.

Ensure an assessment is on file

Crucial to ensuring children's welfare is promoted is that up to date assessments are undertaken and held on file. These must consist of thorough information that has been systematically collected, evaluation / analysis of this information and a plan of intervention to guide future work. The 'Framework for the Assessment of Children in Need and their Families' (2000) should be adhered to. Reviews and closing and transfer summaries should include evaluation of progress made and the social worker's and family's view regarding effectiveness of interventions being tried. This may indicate another plan.

Analysis should be recorded

Analysis and reflection is a key social work task and evidence of this should be found in the record. Obvious points for this to be undertaken are when assessments and reviews are completed. Analysis should be set out

separately from information about the family. The worker will evaluate information about a child's needs using research, monitor progress, evaluate effectiveness of interventions and justify why a certain course of action is being taken. In addition to in assessments and reviews analysis can be set out at various points on the record when the social worker wishes to record their thoughts regarding any case developments.

The record should be fit for sharing with the service user

Service users have the right to access their social services records and many reports are now routinely shared with service users. Sharing drafts of reports with users is good practice. Perceptions can be checked out with families and areas of disagreement can be noted in the final draft.

Care should always be taken that spelling of names and other basic information is correct. These details should be checked out with the family at an early stage, Mistakes can undermine confidence and give the impression a lack of care is being taken.

The sharing of records can facilitate partnership working. It is crucial that recording is undertaken in a way that conveys respect for the service user. Fact should be distinguished from professional opinion and unsubstantiated opinions or oppressive and discriminatory statements should be avoided. The practitioner should have at the back of their mind when recording that the service user may read what is being written.

Records should be clear and written in a way that the service user is likely to be able to understand. Plain language should be used and jargon avoided or explained. For many service users, particularly those Looked After, the case record may be the main source of information about events, decisions and people in their lives. It is therefore crucial they would gain a sense of their story from reading their file.

Checking over work

Prior to completing a piece of recording it should be read through and mistakes corrected. The spell check should be used. Generally the third person should be used consistently. It is important to be clear about identity, for example, record people's full names and when relevant their job title and the agency they work for, or their position in the family.

Referrals

A referral document must be completed for each family referred to Children's Social Care. A new referral has to be completed for each new episode.

The identity of the person making the referral and their relationship to the family should be clear. It should be possible to tell at a glance the reason for the referral.

In the section 'Relevant Background Information' information should be set out regarding previous Social Care involvement. For previous episodes the reasons for social care becoming involved and any significant concerns should be made clear. The reason for the most recent closing should be noted. Any existing chronology should be referred to. The action plan should be completed and the rationale for the proposed plan should be clear.

If a referral is received regarding an open case (for example a police notification or someone who does not know the case is open makes a referral), this information should be recorded on a contact sheet and linked to the diary. In the drop down box entitled 'Type of Contact' it should be written 'New Referral' or 'Police Notification', as appropriate. The information should be entered on the chronology.

See Appendix One for an example of a referral

Sheets Delete all??

Sheets should be used to briefly note significant events and contact with clients and professionals relating to a case. It is not necessary to provide a blow by blow or very detailed account of every single thing that happens. Practitioners should use their judgement about what should be included in the record.

Entries relating to a single day should be recorded in the same box. Entries should be brief and no single entry should be longer than five lines. More detailed records of events or conversations should be recorded on contact sheets (W6s??) and linked (using the document link function) to the diary. A brief note should be made on the dairy advising of the nature of the link.

It should be noted on the when meetings and home visits have taken place. The details of the actual meeting or visit should be recorded on meeting and contact sheets respectively and then linked to the diary. It should be noted on the diary if a family fail to keep an appointment. Delete all???

Letters Delete all??

Letters sent by Social Care should be attached to the diary and a brief note made on the diary stating whom the letter is to and the nature of its content.

It should be noted when formal written correspondence is received in relation to a case. The note should state the nature of the correspondence and whom it is from. If an electronic copy is provided this should be attached to the diary sheet. If a paper copy only is received it should be recorded that the copy is in the paper file.

Emails delete all??

Lengthy or informal emails should not be copied and pasted onto diary sheets. They often contain irrelevant information and can make the record hard to follow. If the content of the email is important the key points should be summarised. If the email is formal and important it should be attached to the diary with a note advising of its content and whom it is from. All emails from the Social Services Emergency Duty Team (EDT) should be pasted onto contact sheets and linked to the diary.

How to make a document link delete all

When you have completed a contact or meeting sheet go to 'Edit' then select 'Copy at Link' then select 'Document Link'. The go to the diary and place your cursor on the attachments box and press 'Paste'. Alongside this in the 'Dairy Entry' box write a brief note advising of the nature of the link.

See Appendix One for examples of diary records

Contact Sheets Delete all??

Information regarding important contacts with clients or professionals should be recorded on contact sheets. The following types of contacts should always be recorded on contact sheets:

- Home and office visits with children and families (including statutory visits)
- Emails from the Emergency Duty Team (EDT)
- Advice from Family Support and Child Protection Advisors (FSPCAs)
- Supervision decisions
- Important telephone calls or calls that require a more detailed record than is appropriate for the diary sheet.

The contact sheet has a drop down box where the practitioner must record the nature of the contact. If none of the existing categories are appropriate then you should briefly note the nature of the contact here. If *Home Visit CP* is selected a prompt will appear for the details which must be recorded regarding such a visit.

Contact sheets should be completed with the date of the contact not the date they are written.

Contacts about the same issues carried out over the same day can be recorded on one contact sheet. Otherwise contacts should be done individually.

Contacts should be focused. It can be helpful in terms of clarity to use headings within the contact sheet that focus on specific issues.

You are required to indicate if the contact describes a critical incident or is of high importance. A contact should be marked as a critical incident if it describes a child protection incident or concern. A contact is of high importance if the practitioner judges that the information is important now and that it would still be important in a years time.

Records of home visits should explicitly state which children were seen and whether they were seen alone.

Once a contact has been completed it should be linked to the dairy sheet with a note on the diary advising of the nature of the contact.

See Appendix Two for examples of contact records

Meeting Records Delete all

Meeting minutes should be recorded on a meeting record sheet. Examples of types of meetings that should be recorded here are Child Protection Conferences, Network, Professionals, Legal Planning and Planning. (N.B. Child Protection Conference Secretaries will usually minute Child Protection Conferences and Review Conferences).

The practitioner must select from the drop down box the type of meeting. If none of these are accurate the social worker should type here a description of the type of meeting held.

It is necessary to concisely record the following:

- Who was present at the meeting and their role and what agency they are from
- Brief record of discussion (it may be useful to use subheadings). Information regarding each child and their needs should be recorded. Progress in relation to any plans made should be made clear.
- Decisions made and who is responsible for carrying out each decision out and timescale set for this when relevant. The rationale for each decision should be clear.

Assessments

Assessments are undertaken to determine the needs of children and families and plans for those needs to be met. When an assessment is undertaken the reason for the referral is explored and information is systematically gathered. This is then analysed by the worker and an understanding emerges of the needs of the child, the parenting capacity within their family, and the impact on the child of any difficulties. This information is used to determine what plans need to be made to ensure the child's optimal development.

Following receipt of a referral a decision must be made regarding whether an initial or core assessment should be undertaken.

Initial Assessments

The Framework for the Assessment of Children in Need and their Families advises that the decision to gather more information constitutes an initial assessment. An initial assessment is defined as a brief assessment of each child in the household that should be completed within a maximum of seven working days following referral. Information should be gathered about the family according to the dimensions of the Assessment Framework. Initial assessments determine whether a child is in need and involve formulating a plan to meet any identified needs.

In order to complete an initial assessment you would need to:

- Compile a chronology and consider its implications
- Conduct at least one meeting with the family
- Meet with each child and obtain their views
- It may be appropriate to liaise with professionals or agencies involved with the family to gather information to inform the assessment.
- Propose a plan including the nature of any services required and whether a further more detailed core assessment should be undertaken

If the referral is in relation to a young person aged 16 or 17 presenting as homeless, and there are other children in the family, the initial assessment should address whether further assessment needs to be undertaken in relation to the other children in the family. Check with Ian

Core Assessments

Core assessments are in-depth assessments that address in detail the child's needs and the capacity of their parents or caregivers to respond appropriately to these needs within the wider family and community context. Core assessments must be completed within 35 working days of a decision being made to undertake a core assessment. The assessment will involve other professionals and agencies; information about the family should be obtained

from those involved in the family's care and specialist advice, or assessment regarding specific areas, may be obtained to inform the assessment.

To complete a core assessment you will need to:

- Compile a chronology and consider its implications
- Meet with the family on several occasions and at least once in their home.
- Meet with each child and obtain their views
- Gather information from involved agencies and professionals
- Request that other assessments are conducted by professionals of other disciplines to address identified needs where this is indicated
- Analyse the information gathered which will provide an understanding of the child's circumstances and inform planning, case objectives and the nature of service provision.

Core assessments should be undertaken if section 47 child protection enquires are initiated and where there are suspicions or allegations about child maltreatment and concerns the child may be suffering, or likely to suffer, sign harm. Core assessment may also be undertaken if the family's needs are complex, if there has been a long history of concerns and Social Services involvement, or if a more sophisticated understanding of a family's needs is desirable.

It may be decided at point of referral to immediately undertake a Core Assessment.

If while an initial or core assessment is being undertaken it becomes apparent immediate action is necessary to safeguard children from danger this should be carried out straight away rather than waiting for the full assessment to be completed.

Completing an assessment

Before you start writing an assessment it is necessary to read over the information you have gathered to inform your assessment.

Pertinent information you have gathered should be set out on the assessment form under the headings provided. You should use the subheadings for each of these headings that are set out as prompts.

An assessment can be broken down into three distinct stages and the following factors should be considered regarding your recording at each stage:

Stage One: Information Provision

- Information provided should be comprehensive.
- Information provided should be collected from a variety of sources and include the social worker's observations of the family
- Department of Health guidance *Assessment Framework for Children in Need and their Families* should be used.

- Information about each child in the family should be included.
- Information provided should be child centred.
- Factual information should be set out separately from the workers opinions / analysis.
- The views of the child(ren), their parent(s) / carer(s) and involved professionals should be represented.
- Information provided should be set out under the appropriate headings and subheadings.
- Sufficient information must be provided to enable the assessment to make sense to someone unfamiliar with the case
- Care should be taken to avoid overly descriptive information

Stage Two: Analysis

- Information about strengths and needs should be set out. If risks are identified the worker should be explicit regarding what these are
- The implications of the chronology should be considered
- Relevant research should be considered
- Views and hypothesis of the social worker regarding the sense they make of the family's situation should be set out. For example, regarding whether they feel the child's emotions and behaviour are cause for concern and their view regarding the cause of any difficulties.
- Observations and judgements should be backed up with appropriate examples
- Balanced judgements should be made about the children's needs and their parents' capacity to meet those needs. (Primacy should be given to the children's needs if these conflict with those of their parents).
- An assessment of the likelihood of parental change should be included (i.e. whether parents are willing and able to achieve identified goals necessary to promote their children's well-being).

Stage Three: Plan to Meet Identified Needs

- A plan to meet the family's needs should be set out. It must be appropriate and proportionate to the risk and complexity of the case
- Plans should identify different interventions and services that may meet identified needs and evaluate different options.
- Interventions must be appropriate to the urgency of the child's needs at each stage of their development. Consideration should be given to whether the changes needed can be achieved within timescale consistent with those of the child
- Plans should identify persons and agencies responsible for planned interventions and services
- Plans should take into account the wishes and feelings expressed by the family (whilst not necessarily meeting current expressed wishes)
- Plans should identify desired SMART outcomes for child and family: specific, measurable, agreed, realistic, time-limited
- Plans should clearly identify non-negotiable goals; goals required for child safety
- Plans should identify goals that must be achieved before the case can be closed.
- Plan should include a proposed deadline for subsequent case review

- The frequency for home visits to be undertaken must be stated.

Difference and Diversity

Key to ensuring equality of opportunity and inclusive practice in assessment work is responding appropriately to difference and diversity. Department of Health guidance in the *Assessment Framework for Children in Need and their Families* and *Working Together to Safeguard Children* covers this area. The key points are summarised here.

The focus in all assessments should be on the child as an individual who has the right to grow up to achieve their potential and be safeguarded from harm. When undertaking assessments important areas that influence child development will be explored including genetic factors, the quality of attachment to their primary caregivers and the quality of their every day life experience.

It is also crucial to consider the impact of any disability, as well as the influence of race, culture and ethnicity on the child and their family, ensuring this is done in a non-discriminatory way.

Disability

It should be borne in mind that although all children have the same developmental needs the pattern of progress for individual children may vary because of factors associated with health, impairment and disability. When considering development or behaviour that is outside the range of what may be expected of the child given their age, it is necessary to consider to what extent this is attributable to any disability, and also to any other factors that influence child development

Consideration must be given to how the extra care needs of a child with a disability may impact on their caregivers and how they can be best supported.

Race, Culture and Ethnicity

As soon as possible when a referral is made information about race, culture and ethnicity should be ascertained. This is crucial in terms of helping to understand the family and ensure that the service is tailored to their needs. Information about the family's ethnic origin, ethnic category, language and religion should be recorded on the Basic Information Sheet on the Assessment System. The family should be asked to define each of these things, choosing from the list available in the drop down boxes for ethnic category (based on the census categories), language and religion.

It is crucial that judgments regarding race, culture and ethnicity are sensitive and informed. The worker must be sensitive to different family, lifestyle, and child rearing patterns that may vary across and within ethnic and cultural groups. Consideration must be given to the religious beliefs and traditions of

different racial, ethnic and cultural groups and how these influence attitudes and behaviour, and the way family and community life is structured and organised. How these things may impact on the child's well being and development must be considered. Judgements should be based on evidence relating to both the strengths and needs of a family.

Workers must be aware of the effects of discrimination that black and ethnic minority people may be subject to and how this may affect them adversely. Particular care should be taken to ensure services that are offered meet client need, which may involve for example using interpreters or resources that cater for specific groups.

A non judgemental approach involves not making assumptions and guarding against myths and stereotypes, both positive and negative, of black and ethnic minority families.

Department of Health Guidance is clear that cultural factors neither explain nor condone acts of omission or commission that place a child at risk of significant harm. Anxiety of being accused of racist practice should not prevent the necessary action being taken to safeguard a child.

See Appendix Three for examples of assessments

Recording Supervised Contact Sessions

Supervised contact tends to be of children and parents who live apart. This may be following children being removed from their parents care within the context of Care Proceedings. Supervision of contact may be necessary to ensure the children's safety but another important purpose of supervised contact is so that observations can be made of parent-child interaction.

For contact taking place in the context of Care Proceedings information from the contacts will inform assessments of parent-child attachment. The behaviour of children and their parents during contact reveals important clues regarding who is important to the child, their expectations of their parents and how their parents respond to them. Information from supervised contact will help social workers address questions such as whether parents are able to meet their child's needs, whether contact is a good experience for the child, and whether continued contact with a parent will help or undermine the stability of a child's permanent placement away from their parent.

Reports of contact sessions will be read by social workers, and sometimes by the Courts, and detailed and descriptive reports are very useful in helping determine whether contact is the children's best interests.

For contact sessions with children in permanent placements, where the purpose of contact is for them to maintain a relationship with their parents, there may not need to be as much detail, but information around whether contact appears to be beneficial for the child, and whether the parent responds appropriately to the child and is supportive of the permanent placement should be noted, as well as a summary of what happened during the contact.

The following areas should be addressed when cases are in court proceedings and may be relevant for other types of contact as well.

- Names and roles of those present
- Date of contact and time contact was scheduled to begin and end. If the actual times of contact varied from these the reason for this and times the contact occurred during should be noted.
- Regarding the parent(s):
 - Their interaction with the child at the beginning and end of contact (how they greet the child and how they end the session)
 - Whether during the session the parent concentrates their attention on the child and actively attempts to involve the children in age-appropriate conversation, play or physical affection.
 - Whether they demonstrate emotional warmth and concern about the child
 - Whether they are attentive and responsive to the child
 - Whether they manage the child's behaviour appropriately

- Whether the parent did anything that upset the child, or anything that had a positive impact
 - Whether the parent appears to be supportive of the child's placement (for example telling them to be good in the placement) or if they appear to be undermining the child's ability to form a good relationship with their current carers (e.g. by making derogatory comments about their carers)
 - Whether the parents give the children any information that is confusing, unhelpful or untrue (for example telling their child to inform their social worker that they want to return home, or telling the child they will be returning home soon when this is not yet known)
 - Whether the parent spends time not engaged with the child (e.g. outside smoking, speaking at length with the contact supervisor, or the parent is withdrawn)
 - Any concerns regarding the parent's behaviour (for example if they are aggressive), or concerns they may have been under the influence of drugs or alcohol, should be set out.
- Regarding the child(ren):
 - Frame of mind of the child prior to contact and following contact if this is observed.
 - Whether the child came to and left contact willingly and without distress or whether there was any reluctance
 - Behaviour of the child on first seeing and later on leaving their parents
 - What the child spends their time doing during the session
 - Whether the child approaches the parent for play, affection, help or comfort (whether they attempt to have these needs met by others present)
 - Whether they spend time in conversation or play with their parent
 - How they respond to the parent
 - How the child responds if the parent leaves the room
 - Whether the child does anything to indicate they wish to avoid the parent or are anxious at the parent's presence (e.g. the child may withdraw through play or may often try to leave the room)
 - Describe any behaviour outside the normal range of what may be expected of a child of their age
 - Describe if the child demonstrates any distress
 - If more than one child is present at contact details should be given of how the children interact with each other
 - Judgements or views of the supervisor should be noted. It should be made clear what evidence these are based on

See Appendix Four for examples of supervised contact records

Chronologies

Background

The Honourable Mrs Justice Bracewell in 2000 highlighted the importance of chronologies in a case she presided over where the children in the family had suffered chronic severe maltreatment. There has been no protective Social Services action despite a very long history of involvement. It was not until a chronology was compiled in 2000 that comprehensive information was available about a pattern of child protection concerns and failure of the parents to change that triggered emergency court proceedings and the removal of the children from the home. Bracewell stated that if a chronology had been undertaken sooner effective intervention was much more likely to have occurred years ago and the children would have been protected from years of dysfunctional parenting which left them very damaged. Laming re-emphasised the importance of chronologies in his report into the death of Victoria Climbié and recommended all case files carry a properly maintained chronology. Chronologies should ensure social workers are aware of any serious or deep-rooted problems that need to be addressed.

When is a chronology required?

A chronology should be compiled when an initial or core assessment is undertaken. The chronology should be updated when the case is reviewed and prior to important meetings. Up to date chronologies must be available for review by managers, child protection advisors and solicitors prior to child protection conferences, network, professional, and legal planning meetings, and when consideration is given to voluntary care under section 20. Regular audits of chronologies are undertaken of numbers and quality.

Specialist cases/teams

- For Looked After Children who are unaccompanied minors, producing a historical chronology may be difficult since it may be difficult to corroborate information. However a chronology giving an overview of their experiences prior to coming to this country and key events in their life whilst being Looked After must be attempted.
- .

What to include in a chronology

As stated above the purpose of a chronology is to provide workers, managers and in some cases the Courts with a chronological list of significant events in a child's or their family's life. This enables the reader to quickly gain a picture of formative events and patterns of behavior helping to improve decision-making.

A chronology is not expected to be a repetition of the detailed records contained in case recordings, but brief bullet points indicating incidents, events or issues within a family that significantly affect a child's life. Family strengths and protective factors should be included to ensure a full and balanced impression is obtained. It therefore requires familiarity with the case information, and analysis to identify the critical moments in a child/family's life experience.

When completing a chronology all case records should be read. If important data is missing from the file it may be possible to obtain this from the family or professionals who are/have been involved. If it is not possible to read the entire case file in the timescale required then meetings records, assessments and reviews should be read.

Chronology entries should be factual and not include opinion or hypothesis. The prompts below indicate the types of information that should feature in a chronology:

- Family History - including marriages, births, deaths, changes in the make-up of the household, and emigration details as appropriate
- Child's changes of address/school
- Child Protection Case Conferences, Child Protection Registration(s)
- Key Network/Planning/Professionals Meetings and Assessments (For important meetings a bullet point list of plans made should be included and it should be clear whether the plans were implemented)
- Relevant Medical Examinations
- Critical Incidents, including Police Notifications (Form 78s) and section 47 Child Protection investigations, giving rise to concern about the well-being of a child
- Take up/non take up of services
- Case open/closed and whether allocated, held on duty or referred to other agencies - including summarised reason(s) for decision(s)
- Accommodations (including requests for and consideration of accommodation)
- Any behavior of the child(ren) that is of concern
- Concerning information from agencies/individuals e.g. allegations (substantiated or otherwise)
- Recorded positive events or strengths
- History of Court Applications, Hearings and Orders

Chronologies for different purposes

Chronologies may be compiled to gain a sense of a family's history and past social services involvement but may also be undertaken for very specific purposes. For example, information may be needed about a Looked After child's past behavior, experiences of being parented and reasons for placement changes to aid a decision about what type of placement may best meet their needs. Such a chronology may be more detailed than one prepared for a child protection conference or court proceedings. It is

necessary for practitioners to use their professional judgment about how detailed a chronology should be and what events/information to include.

Format Is this how we want it??

It is most helpful to present chronologies in a table format. The record should clearly indicate which child(ren) or family the chronology relates to.

The following headings are suggested:

Date	Significant Event/Issue

It is possible to sort by data in a Word table. This allows the document to be completed out of order and sorted by date upon completion.

Updating

- Existing chronologies on allocated cases should be regularly updated, and updated at a minimum prior to any review, planning, child protection or network meetings.
- Existing chronologies on cases that have been re-referred must be updated at either the point of referral or as part of the subsequent assessment (Initial or Core).
- Chronologies on Looked After Children should be updated, as a minimum, prior to each LAC Review, ensuring that an easily accessible overview of the case is available, covering key events in the child's life, including the period of accommodation.

N.B. When updating a chorology electronically it is necessary to save your changes and then remove the old chronology from the Assessment System and attach the revised version.

See Appendix Five for examples of chronologies

Recording Legal Advice

Legal advice must remain privileged and exempt from disclosure to Guardians and clients. Solicitors providing legal advice make notes regarding the advice they provide so a record is kept by the Borough. Should the social worker wish to record legal advice they have been given this should be placed in a confidential section of the social worker's file of legal papers. This file should not be shown to Guardians who come to view the general social services file. The solicitor for the child will have provided the Guardian with all the legal documents relating to a case.

Legal planning meetings should be recorded but no note of legal advice given should be made. Rather, here should be recorded the reason the meeting was held and the decisions and rationale for them.

Data Standards Delete this section

The social worker is responsible for ensuring that for each of their allocated cases the data within these standards is recorded on the Assessment System/ LACMON file.

That this data is easily retrievable is crucial in enabling the Business Information Team to fulfil the statutory duty of providing central government with information about the Borough's performance. This information being easily accessible helps facilitate effective working of cases when the allocated worker is absent. It also enables the department to obtain an overview regarding work being undertaken with children and families and information regarding the progress of Looked After Children.

Basic Information Sheet on the Assessment System

- For each member of the family / household the following must be recorded:
 - First and surname
 - Date of birth
 - Sex
 - Person number (These are assigned by the team's Business Support Officer)
- The household address must be recorded in full (including postcode) as the NEW FORMAT address. (For Looked After Children this is the address the child was living at prior to them becoming Looked After).
- The ethnic origin, ethnic category, language and religion of the household members should be specified. The family should be asked to define this.
- The person who has parental responsibility for the child should be clearly recorded.

Basic Information Sheets on LACMON

The following must be recorded for each Looked After Child

- Current placement address and postcode
- The name and address of the school they are on roll at. If they are not on roll this should be noted.
- Levels achieved for SATs and GCSEs where relevant
- Whether immunisations are up to date
- Date of initial medical on becoming Looked After

Recording on LACMON

Upon a child becoming Looked After all recording should be done on LACMON. You must request that your Business Support Officer creates a LACMON file and 903 form for the child. To do this the social worker must provide the following information:

- Date child became Looked After
- Legal status of child
- Child in need code (Business Support Officer has a copy of these)
- Type of placement

If a child ceases to be Looked After the Business Support Officer must be informed. Recording once a child is no longer Looked After should be on the Assessment System. Once the Assessment System is used again the LACMON record will freeze and cannot be edited. The worker must therefore ensure all records on LACMON are complete prior to resuming recording on The Assessment System.

Review Sheets for Looked After Children (LAC)

- *Timescales for Reviews*

In response to the question 'was the review completed within the statutory timescales?' the worker should indicate whether the actual review meeting took place within timescales.

- *Education*

Indicate:

- Whether the child has been permanently excluded
- Whether the child has a Statement of Educational Need (SEN)
- Whether or not the child has missed more than 25 days education in the last year
- If the child is 16+ what they are doing now

- *Health*

Indicate:

- If child under five whether their developmental assessment is up to date
- Whether immunisations are up to date
- Date of most recent health assessment / medical examination. (If the child refused this indicate that was the case)
- Date of most recent dental check

- *Parenting*

Indicate whether the child has become pregnant, given birth or fathered a child

- *Offending*

Indicate if the child has received any cautions, convictions or reprimands in the last year.

- *Participation in Review*

Indicate by choosing from options within the drop down box how the Looked After Child participated in the review. Take care to select the correct box.

903 Forms on LACMON

- The latest 903 form should indicate the LAC's current placement. It is necessary to inform the Business Support Officer if there is a placement change. If a child is missing from their placement for more than twenty four hours a new 903 form is needed stating this. The team Business Support Officer needs to be notified if the placement status changes, for example from a foster care to an adoptive placement.
- The business support office needs to be informed if a Looked After Child's legal status has changed to ensure this is accurately recorded.

LAC Visit Forms

- All visits to LAC in their placements should be recorded on visit forms on LACMON. This enables the Business Information Team to easily obtain information regarding how recently each LAC has been visited.

Attachments

- All Basic Information Sheets on the Assessment System should have a chronology attached.
- All LACMON Basic Information Sheets should have an up to date copy of the following documents attached:
 - Care plan
 - Placement Plan Part One
 - Placement Plan Part Two
 - Essential information Part One
 - Essential Information Part Two
 - Personal Education Plan

Dates

- Utmost care should be taken to enter dates that are accurate and correctly formatted (i.e. dd/mm/yy - so 1 June 2005 would be 01/06/05). Dates of birth, person numbers and case numbers should be used consistently.

Timescales and Management Authorisation

This section relates to expectations in relation to how soon social workers should record information. It also highlights which documents need management authorisation.

Information about child protection concerns should be recorded as soon as possible and within 24 hours. In cases where there is child protection information relating to children who have just become known to Social Care and the case then this information should be emailed to the Emergency Duty Team along with details of the family composition and home address. Should we delete all above paragraph?

Document type	Timescale for recording	Management authorisation required?
Referral	Within 24 hours	Yes – manager signs off
Initial assessment	7 working days	Yes – manager signs off
Core assessment	35 working days	Yes – manager signs off
Reviews	First review to be completed within three months of the assessment being completed and further reviews to be completed within six months of the last review being completed.	Yes – manager signs off
Telephone contact with professional or family	Within 24 hours if related to child protection concerns. All other information to be recorded within 3 working days.	No
Office / home visit	Child protection visits (for section 47 enquiries and to children on the Child Protection Register) to be recorded within 24 hours. For all other visits, a note	No

	<p>should be made within 24 hours if the children have been seen, and any concerns noted, and the full write-up should be completed within 3 working days.</p> <p>If children are not seen on any planned home visits then this should be clearly noted in the diary.</p> <p>If a child on the Child Protection Register is not seen by the social worker within the timescales set in the child protection plan the line manager should be informed and a record made of the contingency plan. If a child is not seen by the social worker within two weeks of the missed appointment the conference chair should be contacted and a record made of the contingency plan.</p>	
Meetings	<p>All meetings bar Child Protection Conferences: Details of those present and decisions made should be recorded within 24 hours. Record of discussion should be recorded within 3 working days.</p> <p>Child Protection Conferences: Decisions to be recorded within 48 hours. Full record to be completed within 15 working days.</p>	<p>Meeting chairs should sign off meeting records.</p> <p>For core group meetings the chair should sign off the first meeting record and the line manager should sign off future meeting records.</p>
LAC visits	If the child has been seen	These must be

	<p>this should be noted within 24 hours.</p> <p>The full visit record should be completed within 3 working days.</p>	<p>recorded on statutory visit form—manager signs off.</p>
Closing of cases	<p>Once a decision has been made to close a case and all outstanding work has been completed the case should be closed within three working days.</p>	<p>Manager signs off</p>
LAC documents	<p>Essential Information Part One and Placement Plan Part One should be placed on file within 24 hours of child being placed</p> <p>Placement Plan Part Two should be placed on file within three working days of the placement planning meeting taking place (which should be held within 7 days of the placement starting).</p> <p>The Care Plan and other documents to be completed and placed on file by the first review.</p>	<p>No</p>
Personal Education Plans (PEPs)	<p>These should be placed on file to the system within three days of the PEP meeting taking place. (PEP meetings must take place within 28 days of a child becoming looked after, and then after three months and then on a six monthly basis).</p>	<p>No</p>

Appendix One – Referrals
Delete this section

Royal Borough of Kensington & Chelsea Children and Families Division

REFERRAL.

Started by Richard Davis on 01/10/2003

Case status: LAC only
Family

Updated by Jane Brown on 02/10/2003

Case category: Children &

Date of referral 01/10/2003

Time of referral

Name
Bloggs

Case Paper No.
01346079 / 2

Person No.
07065821

Name of Referrer
Ms Delia James

Address/Agency
Head Teacher
Endsley School

Telephone
SEE BIS

Relationship
School/teacher/Edu
cation Welfare

Detailed relationship (ward in hospital)

Method of referral
Person taking referral

Telephone
Richard Davis

User aware of referral?
Job title

Yes
Social Worker

Date last closed 16/06/2003

By area-setting/team

Borough of origin

RBKC

Service User's Address
XXXX

Telephone
XXXXXX

Family/Household members

Person No	Surname (title)	First Name	Relationship	DoB	M/F
07065820	Bloggs()	Janey	Subject	XXX	F
07065810	Bloggs()	Emily	Sister	XXX	F
07065830	Bloggs()	Dean	Brother	XXX	M
04476700	Bloggs()	Louise	Mother	XXX	F
04476710	Bloggs()	Adam	Father	XXX	M
	()				
	()				
	()				

Number of children involved in this Referral: 3
Extra Person information: Other names:

Is help needed with communicating/interpreting? No **Specify**

Ethnic origin	Ethnic Category of subject	Language	Religion
White British	White Birtish	English	None

Significant family members/others not living at household address

Name	DOB	Relationship	Address	Telephone
Mr D Bloggs		Uncle Paternal	XXX	XXX
Dr X		Friend	XXX	XXX

Agencies and others involved

Name	Relationship/ Role	Core Group?	Address	Telephone	E-mail
Dr James	General Practitioner	No	XXX	XXX	

Reason for Referral:

Telephone call received from Delia James, head teacher of Endsley school where all three children attend.

Ms Slavin reported:

That Janey and Dean present as aggressive at school.

That the children look unkempt, and will sometimes smell. Janey has nits.

Dean has reported his father hits him with a slipper.

The family have reported that Dean has been hitting and kicking Emily. Emily has presented at school with bruises in the past.

Yesterday Ms Dean attended a meeting with Mrs Bloggs and John Jones (worker at Parkside Clinic). All three people decided that due to the fact that the family are struggling to set boundaries for the children, that Dean is being violent to Emily, and that the children are looking unkempt, that social services would be asked to assist the family. Mr Jones felt that this work was beyond the remit of Parkside Clinic.

Relevant background information

Children's names were on the child protection register for emotional abuse and physical abuse between November 1999 and May 2002.

Concerns were:

- Mr and Mrs Bloggs's volatile relationship

- Mr and Mrs Bloggs's physical chastisement of the children.

- The children looking unkempt.

- Mr and Mrs inability to set clear boundaries with the children.

The case was closed in March 2003. It was assessed that physical chastisement of the children had ceased and that Mr and Mrs Bloggs were making an effort to improve their relationship. It was reported that the family appeared stable. The family engaged with social services and Parkside Clinic.

Overview/reasons for action

This family have experienced difficulties in the past, and were able to effect positive change slowly with support from social services. The family appear to be struggling at the moment and their situation may have deteriorated since the case was closed. The head teacher of the school claims to have called social services several times and requested social services action. Brent Hartke has confirmed verbally that he has had conversations with Ms Slaven.

Social Services should visit the family home and meet with the family to establish if there is a role for social services. Social services to speak to children alone to establish extent of physical chastisement from parents.

Social services to liase with Parkside Clinic.

Action Plan

**Action
whom**

By when

By

Social services to send appointment for home visit to meet with family.

Social worker could visit school to see children there.

Social services to liase with Parkside.

Above tasks to be done once manager approves proposed plan.

Is an assessment needed? No

See separate guidance about when S47 assessments should be undertaken.

Critical incident? No

Attachments:

Recommendation by Assessor
Reason for recommendation (inc. re: assessment)

Assess/Continuing Plan
Further exploration is
necessary as outlined
above to establish
whether there is a role for
social services
involvement.

Recommended by Richard Davis
Decision of Team Manager required (select)

Date 01/10/2003
Jane Brown

Team Manager decision
Allocate to

Assess/Continuing Plan
DUTY

Reason for decision, comments and other directions

Initial assessment
indicated. Arrange duty
visit.

Needs Quantity

Medium

Signed Jane Brown

Date 02/10/2003

Appendix Two – Diary Sheets Delete this section

Example of a good diary entry:

Date	Diary entry	Attachments	Recorded by
09/03/2005	<p>Email received from Emma Reed (Family Resource Project) advising that Mr and Mrs James attended the parenting group yesterday.</p> <p>Letters sent to school, family and health visitor confirming network meeting to take place on 11/03/05 at 2.30pm – see attached.</p> <p>T/C to Dr Lee (Parkside Clinic) to obtain update – see contact sheet.</p>		A Worker
11/03/2005	<p>Network meeting. See link.</p> <p>T/C with Esther Edemski, OT for Mrs James. She has fitted appropriate equipment in the home and there will be no further OT involvement.</p>		A Worker
12/03/2005	<p>Office visit from Mr James requesting financial assistance – see link.</p> <p>Appointment for Jonny to visit Harefield School arranged with Mr James and the school for 5 April 2005 at 2pm.</p>		A Worker

Example of a poor diary entry (comments in bold):

Date	Diary entry	Attachments	Recorded by
09/03/2005	<p>Email from Emma R: Dear A, Hope you are well. Just to let you know that Mr and Mrs James did attend the parenting group yesterday! Take care and see you soon Emma.</p> <p>Cutting and pasting this email is not appropriate. The tone is informal and not all of the information is relevant.</p> <p>T/C to Dr Lee. He said that the family has now attended two sessions. There had been a difficulty finding an appropriate room due to Mrs James's disability. They may arrange for the family to be seen elsewhere. The plan for the clinic is to have two more sessions and then they will think about what to do next. First impressions are that Mr and Mrs James are having relationship difficulties that are affecting Johnny who appears to be a terror. Dr Lee is unsure if the family will continue to attend sessions since they do not seem keen. Mr and Mrs James have asked about whether they might be able to have sessions separately.</p> <p>The tone is unprofessional and there is too much information here. A detailed conversation should be on a contact sheet.</p>		A Worker
11/03/2005	<p>The network meeting went ahead today as planned. Everyone attended. Decisions were that family working agreement is followed and that the school will continue to support Johnny and the benefits agency will be contacted.</p> <p>Information about the network meetings should be recoded on a meeting contact sheet, including full details about who was present, what was discussed and decisions made and who was responsible for each.</p> <p>T/C with Esther Edemski, OT for Mrs James.</p> <p>Details of the telephone call should be stated.</p> <p>'some other things' is too informal.</p>		A Worker
12/03/2005	<p>Mr James was given £10.00 when he came into the office. I mentioned to him about the</p>		A Worker

appointment at Harefield school and he said any time would be good for him.

More information is needed about why financial assistance was given. This should be recorded on a contact sheet.

T/C to Harefield school –appt offered for 4 April.

T/C to Mr James. He can't do this appointment as he has a doctors appointment.

T/C to Harefield School. They offered an appointment on 5 April.

T/C to Mr James. He was asleep – Johnny answered the phone. I asked Johnny to tell Mr James to call me back.

T/C from Mr James – confirmed appointment for 5 April. He said that he is looking forward to seeing the school.

The details of all these conversations are unnecessary. The arrangement simply needs to be recorded.

Appendix One – Contact Sheets Rename W6? Do we want this? –
I think it is too wordy

Example of a good contact record:

Date 10/04/2005 **Time** 17:07:49 **Recorded by** A Worker

Type of contact Home Visit CP

Details

Nature of contact:
Home Visit

Purpose of contact:

To further investigate an allegation John Smith has made to his class teacher that he has been hit with a belt by his father. This is part of a Section 47 Enquiry.

Arrived at the home address at 4.30 pm. Mr and Mrs Smith and John were present. The family were expecting us, and let us in voluntarily. After introductions were made, we agreed that I would speak to the parents, whilst Jane Debbin (Social Worker) spoke to John in his bedroom. The parents were in full agreement with this course of action

Meeting with Mr and Mrs Smith

I gave Mr and Mrs Smith details of the allegation John had made. Mr Smith immediately denied that he had hit John with a belt, but did admit to using his hand – hitting him once around the head last Sunday, after a family argument blew, in his words ‘out of proportion’. He denied hitting him on a regular basis, and said that he deeply regretted his actions, explaining that he had acted out of pure frustration, as John had refused persistently to do as he had been told.

Mrs Smith verified this account, and explained that she had been extremely angry with her husband for acting in this way – it was, she maintained, out of character for Mr Smith.

I asked how they usually disciplined John, and they explained that if he behaved badly they would withdraw treats or send him to his room for a short period of time.

I asked what might have led Mr Smith to act in this way, and he told me that he had just been made redundant from his job.

I observed a strong rapport between both parents. For example there was good eye contact between them, and they were able to wait to hear the other speak without interruption.

MEETING WITH JOHN

John was open with Ms Debbin, and explained that he had exaggerated the incident on Sunday. He told my colleague that he was distressed that his father had hit him, and knew that saying what he did would ‘get his Dad into trouble’.

He told my colleague, without prompting that he loved his parents very much, and knew they had been under pressure recently. He just wanted ‘everything to be alright’ (his words). My colleague observed that John maintained good eye contact and spoke spontaneously. His room was fully of games and toys that were appropriate for a child of his age.

No visible bruising was observed on John. Note that the teacher asked to see John’s

back yesterday (where John said his father had originally 'belted' him, and could find no mark or bruising).

JOHN WITH PARENTS

Ms Debbin and I both observed John with his parents after the separate interviews. He came rushing out of his bedroom and hugged his father, who cuddled him and told him that 'things would be ok'.

CONCLUSIONS

In conclusion, my colleague and I were satisfied that this was an unfortunate one off incident. Mr and Mrs Smith were very aware that Mr Smith's behaviour on Sunday was inappropriate, and both suggested without prompting alternative ways that the situation could have been dealt with. Mr Smith recognised the stress he had been under, and undertook to identify appropriate support for himself.

ACTION

Complete S47 assessment, liaise with TM and PCPT, in particular discuss whether a medical still needs to take place. Carry out GP and school checks.

Example of a poor contact record:

Date 10/04/2005 **Time** 17:07:49 **Recorded by** A Worker

Type of contact Home Visit CP

Details

Home visit to Mr and Mrs Smith. They let us in and John was there. I told them why we had come – they were expecting us. I spoke to the parents whilst my colleague spoke to John alone. Mr Smith denied hitting John with a belt, but did say he had hit him around the head in a fit of temper. Mr and Mrs Smith were upset about this, but said it wouldn't happen again. Mr and Mrs Smith seemed to get on well.

My colleague met with John alone. He said he had made up what had happened the other day, because he wanted to get his dad into trouble. He said he loved his Mum and Dad and it hadn't happened before.

When John came out he hugged his Dad who told him it would be ok.

We were satisfied this was a one off incident.

Differences between the two:

Contact sheet one

- The first contact sheet clearly explained the purpose of the visit.
- Any observations made were backed up with examples.
- Headings are used, which add to the clarity of the record.
- There is a clear record of any further action needed.

Contact sheet two

- No clear explanation of the purpose of the visit
- Any observations made are not backed up with examples.
- Headings not used making the record hard to follow
- No clear record of what further action is required.

Appendix Four – Initial Assessments (an what do you think? Do we need this?)

Example of a good initial assessment

Name
Frankel

Case Paper No.

Is there a child with a disability on the case? No

1. Reason for current Assessment

Mohammed was seen at Chelsea and Westminster Hospital by Dr Ed Williamson (consultant paediatrician) in February 2004. Dr Williamson expressed concern about Mohammed who in his view presented at his clinic as a very unhappy boy. Mohammed has complained of pains over many years but no medical cause has been found for any of his symptoms.

Dr Williamson asked Mohammed if he was to be able to do anything to help him to be happier what that would be. Mohammed replied 'make my life normal'.

A home visit was carried out by a Social Services duty worker on 15/03/04 to investigate the current family situation and to explore Dr Williamson's concerns.

Equalities Monitoring

Is help needed with communicating/interpreting?

Yes

Specify

Farsi

Ethnic origin

Ethnic Category of subject

Language

Religion

Afghanistan

Asian/Asian
British - Other
(specify)

Farsi

Muslim - Sunni

2. Family and Environmental Factors

Information & views of other agencies

Family history, Wider family, Family functioning and social integration, Community resources, Housing,

Employment, Finance. For core assessments please indicate the implications of family history for each child.

Family history and functioning

The family has been living in the UK since 1997 after fleeing from Afghanistan where the father Mr Frankel was a victim of torture. As a result of his experiences Mr Frankel has mental health problems. He has been diagnosed with Post Traumatic Stress Disorder. He and his wife report that he has been physically violent towards his wife, the most recent incident being three months ago. The domestic violence began following Mr Frankel being imprisoned and tortured. Prior to that the couple report that the relationship with free from violence and Mrs Frankel reports Mr Frankel was a normal, loving and caring husband and father. Mr Frankel is receiving treatment and is under the care of the Community Mental Health Team based at Chelsea and Westminster Hospital. The family report that Mr Frankel's mood is better in recent months but that she continues to spend most of his time in his bedroom not interacting with anyone. Mrs Frankel said that there are times when he comes out and spends short periods of time with the family but this happens very rarely. He also normally eats on his own in his room.

The relationship between the children and their mother and between the siblings appears to be close, loving and supportive. The family members present as being very protective of each other because of their father's violence and aggression. It seems that the children help and support their mother considerably and take on a fair amount of responsibility for themselves and their parents.

Wider Family; Social Integration

The family seems to be fairly isolated. They report that they have no friends or extended family in this country that offer practical or emotional support.

The older daughters Lydia (19 years) and Tatania (18 years) attend college and appear to be fairly independent according to what their brother Arber said. They both live at home and Mohammed said that his oldest sister helps to look after all of them.

Arber (15) is in Year 11 and says he has friends at school. Arban (13) is in Year 8 and also said he has school friends. Mohammed does not appear to have many friends and tends to seek his brothers out at school. He also does not mix socially outside of school. Mrs Frankel says that she has some Iraqi women friends and sometimes attends the Mosque in Notting Hill to meet with other women. Apart from these links the family seems to

be very close knit and it does not seem that they have a strong support network.

Housing, Employment, Finance

The family lives in a council house in Fulham Road, SW 10. They have been living there for approximately four years. Neither of the parents work and the family is reliant on benefits. They are in receipt of their full benefit entitlement. Mrs Frankel said that they are managing but they are not able to save any money.

3. Assessment of child/young person's needs

Number of children included in this Assessment: 3

Arber (15)

Physical and Emotional Health

Arber appeared to be in good health. He is tall and presented appropriately. He was very polite and seemed mature for his age. He reported that he is fine and said he is not experiencing any problems. Mohammed said that Arber is like the father in the house. Arber agreed that he does take some responsibility for the other children, especially his brothers for example making sure they go to school. This did not seem to be a problem for him.

Education; Social development

Arber said that he is doing fine at school. He is concentrating on his schoolwork and GCSEs and says he often spends time in the library where can study and get his work done. He said he is not having any problems at school. He would like to do his A levels. Arber said he has school friends.

Family relationships

Arber said he does not have much to do with his father. He appears to have a good relationship with his mother and siblings.

Arban (13)

Physical and Emotional Health

Arban also appeared to be in good health. He was quiet during the home visit, but said he is fine and did not appear to be having any difficulties.

Education; Social development

Arban said that school is going fine and that he has friends at school.

Family Relationships

No concerns identified.

Mohammed (11)

Mohammed is the youngest of the five siblings.

Physical and Emotional Health

Mohammed appeared physically healthy. Although he has had a number of physical complaints (pain, night sweats, poor appetite) no medical problems have been identified. Mohammed recently had an MRI scan of his spine that was normal. Mrs Frankel said that Mohammed has night sweats. Mohammed said he does not have nightmares. The family report no problems.

Mohammed said that he is unhappy because his father is not well. He said he is unhappy and worried about his father most of the time. He is also very scared that his father will be violent to his mother again. He said he does not know how his dad will be when he comes home from school everyday, i.e. what his mood will be or how he will be feeling. He said he worries that something is going on that his parents are not telling him about - he did not know what this might be, but said he just "has a feeling". Mohammed is also sad that his father does not spend any time with the family and is always in his bedroom on his own. Mohammed said he hardly ever sees him or gets to talk to him. He said that other children's fathers do things with their children and take them out but his father does not do these things. While he was talking his mother became very tearful and Mohammed said that this happens often and upsets him. Mohammed said that his life would be normal if his father got better. Mohammed said that he would like some help to deal with his worries and feelings.

Education; social development

Mohammed is in Year 7, his first year of secondary school. He said school is fine but that he never seems to get any work done as in his mind he is half at home and half at school. He said he has difficulty concentrating as he is always worried about what is happening at home when he is not there. Arber said that Mohammed does not seem to have many friends and will spend break times with Arber rather than his own peers. His mother said he has "sort of" struggled to make friends at school. It seems that Mohammed has also been targeted by some older bullies who have stolen his school card as well as his school bag on two occasions. Arber went with his mother to the School parents evening and Mohammed's teacher said that Mohammed is very quiet and just gets on with his work, but did not raise any other concerns. Mohammed said he does not think that his teachers had noticed that there is anything wrong. Arber and Mrs Frankel said that the teachers are not likely to be aware of Mohammed's home situation.

Family Relationships

Mohammed is obviously very sad about his relationship with his father and longs for this to be different. He is also clearly scared of his father because of Mr Frankel's violence and aggression towards his wife. Mohammed seems to have a very close relationship with his mother and I observed affectionate interaction between them. However, Mohammed is carrying a burden of responsibility that is beyond what he should have to take on - he worries about her and seems to feel he is responsible for protecting her. He also appears to offer her emotional support as well as a lot of practical help with household chores. He seems to stay at home most of the time apart from

when he is at school and this seems to be mostly because he is worried about what is happening at home. Mohammed said he gets on well with his siblings and has a good relationship with them. He looks to Arber as the head of the household and said that his sisters help to take care of the family.

Interests

Mohammed does not do any extra-curricular activities. Arber said that he used to attend swimming club after school and Mohammed said he enjoyed this. When he is at home he does his homework, sometimes reads and watches specific TV programmes. He does not seem to do anything else. He could not think of any activities that he might like to pursue but said that he would be interested in doing something outside of school and home.

Wishes and Feelings

Mohammed wishes that his father would get better. He wants to have a "normal life", which he equates to having a "normal" father. He seems to be overwhelmed by feelings of unhappiness and anxiety.

4. Assessment of Parent's/Carer's Parenting Capacity

For Core Assessments please indicate the impact of the parent's/Carer's parenting capacity on each child.

Basic Care

The children appear to be physically well cared for although it seems that they take some of this responsibility themselves. Mrs Frankel seems to be a hard-working housewife and mother who has coped relatively well and has managed to keep her family together under very difficult circumstances. Mr Frankel does not have any involvement in the parenting of his children or in the running of the household.

Ensuring safety

The children and Mr and Mrs Frankel all report that Mr Frankel has not been violent towards the children. However, it appears they have been present in the home when Mr Frankel has hit Mrs Frankel, which will have had a negative emotional impact on them. In terms of this violence, the family report that this has always involved hitting and not other violence, and that on one occasion Mrs Frankel did sustain bruising on her face as a result of this.

The children presented as being sensible about looking after themselves and keeping safe. It was evident that they feel a responsibility to protect their mother from attacks by their father.

Mrs Frankel appears to have a strong sense of loyalty towards her husband and does not plan to separate from him. It seems that the children understand this due to their father in the past displaying no undesirable behaviour.

Emotional warmth

Mrs Frankel presented as a loving and caring mother who is concerned about the well-being of her children and does her best for them. She has clearly been deeply affected by her husband's illness and is devastated about the effect this has had on her family and how her children have suffered. Mr Frankel is isolated from the rest of the family and hardly communicates with them, but all the family members feel a responsibility for and loyalty towards him.

Stimulation; guidance and boundaries

The children all presented as well behaved and disciplined. Mrs Frankel is dependant on her children to help her to communicate with others and the children seem to take a lot of responsibility for family matters.

Stability

The family has some stability created by the close and supportive relationships between Mrs Frankel and the children and amongst the siblings. However, instability exists due to the uncertainty and anxiety created by the unpredictable nature of Mr Frankel's behaviour. This seems to be particularly affecting the emotional well-being of Mohammed at present.

Health/disability

Mrs Frankel was tearful during the visit and it appears that she often breaks down in front of her children. It appears that she relies significantly on her children's care and support. Mrs Frankel said she takes sleeping tablets.

Mr Frankel is still very ill as a result of his past experiences of torture, although the family reported that the treatment he has been undergoing has made a positive difference and it appears that he is calmer and less violent. Mrs Frankel said that her husband has an excellent psychiatrist at Chelsea and Westminster who has been very supportive to them both.

5. Other significant information

6. Conclusions

This is a family who have faced extremely difficult circumstances, but who have managed to remain loyal to and supportive of one another in spite of their situation. The older children all appear to be coping well and seem well adjusted. The main concern at present is Mohammed, who is experiencing significant unhappiness and anxiety. It appears that his emotional state has led to somatising symptoms (complaining of physical pain when emotional distress is being experienced) and his emotional

well-being is clearly being negatively affected by trying to deal with his father's condition and the worry and sadness that this is causing him. This is also affecting his ability to focus on his schoolwork, to make friends and to find enjoyment in any activities outside of home and school. Mohammed seems to feel a responsibility for his parents that is beyond what he should have to take on at his age. He is also entering adolescence and the usual difficulties associated with this stage of development will be compounded by the emotional difficulties he is currently experiencing. It is my view that he needs some kind of counseling or therapy as soon as possible to help him to work through his feelings and to learn ways to cope with the reality of his family circumstances. I also feel that he would benefit by engaging in some outside activities that will get him out of the house and enable him to make some friends.

I was also concerned by the distress expressed by Mrs Frankel, who seems to be very emotionally unstable herself and not able to protect the children, in particular Mohammed from seeing her distress, which clearly upsets him. I think that she would also benefit from help in her own right.

PLAN

WORK TO BE DONE/SERVICES with names and dates

What action, including further assessment, is planned to meet child(ren)'s needs as identified above; specify who needs to do what by when.

Please explain how this plan will meet each of the child(ren)'s needs. For core assessments please do a section per child.

Identify contingency plans.

1. Social worker to discuss concerns about Mohammed with his school teacher / head teacher to see what input and support they might be able to provide Mohammed at school. Mohammed and his mother have given permission for Social Services to liaise with the school.
2. Social Services to consult with Dr Williamson and make a referral to an appropriate therapeutic service for Mohammed.
3. Social Services to give consideration to be given to making a new referral to the Child and Family Consultation Service or to the Children's Resource team, specifically for help for Mohammed.
4. Social Services to liaise with GP regarding Mrs Frankel's emotional/mental health and what support might be helpful for her (Mrs Frankel has consented to this).
5. Liase with psychiatrist for Mr Frankel about any strategies or help that may assist Mr Frankel avoiding being violent.

6. Discuss with Mr and Mrs Frankel the importance of the children living in a violence-free environment. The Farsi interpreter from CITAS was very helpful - her name is Mrs Z. Ahmadi and she can be booked again through CITAS.

Example of a poor initial assessment

Name: Jones

Case Paper No.

Is there a child with a disability on the case? No

1. Reason for current Assessment

Andrew's mother came into reception on 25th and asked for money as her benefits had been stopped. She became angry when she was told she couldn't have money and was aggressive to staff. She has had lots of Section 17 in the past.

Equalities Monitoring

Is help needed with communicating/interpreting ?

Specify

Ethnic origin

Ethnic Category of subject

Language

Religion

2. Family and Environmental Factors

Information & views of other agencies
 Family history, Wider family, Family functioning and social integration, Community resources, Housing, Employment, Finance. For core assessments please indicate the implications of family history for each child.

Andrew lives with his mother and sisters on the estate. Their flat is quite shabby. Andrew's mother is on benefits. Andrew's grandmother lives nearby.

3. Assessment of child/young person's needs

Number of children included in this Assessment: 3

Andrew is eight years old. His sisters are aged ten and twelve.

Andrew behaves badly at school sometimes and argues a lot with his mother. Andrew enjoys swimming and tennis. His sisters appear to be doing fine.

4. Assessment of Parent's/Carer's Parenting Capacity

For Core Assessments please indicate the impact of the parent's/Carer's parenting capacity on each child.

Andrew's mother says she finds it hard to manage on benefits. She seemed to be drunk when she came into the office. She says she loves her children but can't buy them everything they need. She doesn't seem to have much support. Andrew's mother says that the main problem facing her family is lack of finances.

5. Other significant information

6. Conclusions

Andrew's mother came into reception to ask for extra money as her benefits had been stopped. She has had lots of Section 17 in the past.

She does seem to have trouble coping. Some extra money would be helpful for her, but I am concerned she may spend it on alcohol.

PLAN

WORK TO BE DONE/SERVICES with names and dates

What action, including further assessment, is planned to meet child(ren)'s needs as identified above; specify who needs to do what by when.

Please explain how this plan will meet each of the child(ren)'s needs. For core assessments please do a section per child.

Identify contingency plans.

Offer some Section 17 money but explain to Andrew's mother that it must not be spent on alcohol. Offer alcohol support services to Andrew's mother.

Differences between the two assessments

Reason for Assessment

Assessment one provides a clear reason for carrying out the assessment. Assessment two is quite vague, just containing information that has been 'dropped down' from the referral.

Environmental Factors and Family History

Assessment one provides a clear account of a family history and environmental factors. Assessment two is vague and gives limited and unsubstantiated information.

Child's Needs

Assessment one addresses the needs of each child separately and contains observations that are backed up with clear examples. Assessment two does not address each child individually, and is mainly descriptive. Judgements are not backed up with examples. No exploration takes place in assessment two as to the children's needs. There is no evidence the children have been spoken to or seen alone. There is no consideration to how their mother's needs may be impacting on them.

Parenting Capacity

Assessment one contains a full assessment of parenting capacity. Assessment two does not contain an assessment from the Social Worker in this key area, but relies purely on mother's own opinion of how she is managing. It also contains unsubstantiated allegations in relation to mother's alcohol use.

Analysis

Assessment one has an analytical framework, whereas Assessment two is more descriptive.

Conclusion

Assessment one consists of a strong conclusion based on the information gathered during the course of the assessment. Assessment two's conclusion is really no different to the introduction, as a full assessment has not been carried out in order to inform a conclusion and plan.

Appendix Five change number– Supervised Contact Reports

Example of a good supervised contact report

Date:

20 June 2005

Present:

Ms Mackintosh – Mother

John Mackintosh – Son

James Mackintosh – Son

Jenny Evans – Contact Supervisor

Times contact scheduled for:

3pm-5pm

Context:

I collected John and James from their foster carer's home at 2.30 and we caught the bus to the contact centre. John said 'I am looking forward to seeing mummy' and showed me a picture he had drawn he was planning to give her. James was reluctant to leave the home, initially insisting on continuing to watch TV and then he took a long time to put his shoes on.

The Session:

Ms Mackintosh was fifteen minutes late. She apologised for this and said that there was lots of traffic and the bus journey took a long time. When she arrived John rushed towards her and embraced her. James continued playing. Mrs Mackintosh first gave John a big hug and then beckoned to James who then allowed her to give him a hug. James then broke away stating 'I want to play'.

Mrs Mackintosh smiled a lot when John gave her the drawing. She gave him a kiss and told him it was very nice and she would put it on the wall at home to remind her of him.

During the session Mrs Mackintosh paid more attention to John, who took part in a game of dominos she initiated. James said he would play but in the end carried on with the toy he was originally playing with. Mrs Mackintosh did not encourage him to take part in the game.

James hurt himself on the toy he was playing with which appeared to be broken and have a sharp edge. He showed this to me and allowed me to comfort him.

The family later went into the garden. They sat on the bench. Mrs Mackintosh asked both boys questions about school and both boys told her a bit about the past week. Mrs Mackintosh listened to what they said and encouraged them to speak by nodding, showing she was listening.

When it came to the end of the session Mrs Mackintosh told both boys that she would see them soon and hugged them both. John became tearful and said he missed her. She told him to be good in the foster care placement and that the boys carer would take good care of them and that it would not be long until they would be back home with her.

Both boys were calm on the way home and spoke to me about television programmes.

Contact supervisor's comments:

It seemed to me that James was much more reluctant to engage with his mother or seek to have his needs met by her. He appears to have a different relationship with his mother to John, who Mrs Mackintosh appears to make more effort to spend time with during the contact. At times James presented as withdrawn and in his own world in the contact. James also appeared reluctant to leave the home and these things raised my concerns about his relationship with his mother. John appeared to enjoy the contact more than James. It is also of concern that Mrs Mackintosh told the boys they would return home to her soon, since as far as I am aware the long-term plan has not yet been decided, and this message may confuse them.

Example of a poor supervised contact report

I collected the boys and we went to the centre. Ms Mackintosh was late – she said it was because of the buses.

She liked John's drawing and spent more time with him during the contact than with James who seemed to prefer to play alone.

John was very sad when the session ended. She comforted him by saying that he would return to her soon.

Differences between the two

Context to the Session

The first example provides useful background information about the mood of the boys on the way to the contact session. The second example does not.

Observations during the session

The first example makes useful observations and ensures that they are backed up with examples. In the second example information is sparse and much relevant information is omitted

Appendix Six change number - Chronologies

Extract from a good chronology

Adams Family Chronology

Date	Event
07/03/1958	Matthew Adams born
17/06/1960	Elizabeth Adams born
13/05/1994	Jacob Adams born
01/08/1994	Jacob fractures skull in fall from pushchair.
01/09/1994	Health visitor reports Mrs Adams presents as depressed and anxious.
01/03/1995	Family move to Hammersmith from Ealing. SSD involved from 1995-1997. Concerns summarized as: physical chastisement, neglect (inadequate supervision, hygiene and home conditions) and poor parenting.
09/06/1995	Jacob seen by GP following nose bruised in fall.
14/01/1996	Debbie Adams born
23/07/1996	Mr Adams admits to slapping Jacob and causing bruising. Dr Green, GP, notes marks on Jacob's face consistent with a slap. Jacob seen in close space of time with bruised eye resulting from a fall.
12/11/1996	While visiting Mrs Adams in hospital (with stomach pains) Mr Adams fails to supervise Jacob adequately and hits him around the head.
01/07/1997	Mr Adams aggressive in meeting with SSD and drags Jacob out accidentally banging his forehead against a door causing a mark.
17/09/1997	Eve Adams born
01/12/1997	Police attended home to investigate complaint Mr Adams harassing a neighbour. Home reported to be in a 'disgusting state'. Mrs Adams presents as depressed and unable to cope.
16/12/1997	Family referred to R.B.K.C SSD by health visitor following Mrs Adams confiding she often hits the children and finds it difficult to cope. Debbie has scab on forehead apparently from falling out of her buggy. Social worker Any Colette allocated.
22/02/1998	Police investigate Mr Adams allegedly slapping Jacob's face.
24/02/1998	Mrs Adams overhead at nursery to say Mr Adams woke up in a bad mood and slapped the children.
03/03/1998	SSD strategy meeting. Decided for Jacob to have child protection medical (conducted 04/03/98) due to concerns about injuries. Concerns noted

	regarding Debbie being involved in multiple accidents.
24/03/1998	Initial Child Protection Case Conference. Discussed that children have sustained many injuries, they appear to be subject to excessive physical chastisement and all children are developmentally delayed. Decided all children to have paediatric assessment, Mrs Adams to attend parenting group, whole family to attend Parkside Clinic for therapeutic support and parenting help. Children's names not placed on Child Protection Register as felt Mr and Mrs Adams cooperating with SSD. The family only cooperated with the medical appointments.

Example of a poor chronology

Jones Family Chronology

20th September 2000 Family present at social services requesting financial assistance and some general advice. They were seen by the duty social worker and a home visit was carried out the next day. The home visit found that the flat was very bare and contained very little food.

27th September 2000 T/C to children's school. Unable to get through.

20th October 2000 Network meeting held. Present at this meeting were the FSCPA, Social Worker, Team Manager, Parents and school. The following issues were discussed: Neglect issues, financial problems.

November 2000 – Met John Jones on the street. He said that he and the family were fine.

Differences between the chronologies

Critical Incidents

Chronology one focuses on critical or significant incidents only. Chronology two lapses into 'diary entries' at times – for example the telephone call to the school.

Precision

Chronology one gives precise and specific information. Information in chronology two is more general, for example 'general advice'.

Key decisions

Chronology one focuses on key decisions. Chronology two does not really detail decisions made, for example, at the network meeting. Instead it gives an account of who was present at the meeting – this kind of detail will be recorded in the record of the meeting itself.

Appendix Seven

Recording Do's and Don'ts

Do

- Do think before you record – Why? Who for? Who else might read?
- Do be concise and clear
- Do record decisions made clearly and obviously
- Do use plain English
- Do record in a timely fashion
- Do remember that the case record is a public document, and users have rights of access; write in a way that conveys respect
- Do include accurate factual information and analysis/opinion separately, and evidence both
- Do in general use the 3rd person (Mrs A, s/he, they) consistently; be clear about identity
- Do remember assessments and reviews may need editing –use spelling and grammar checks

Don't

- Don't repeat – cross refer
- Don't cut and paste without editing
- Don't forget to sign and date reports for meetings
- Don't copy every e-mail into the record- summarise
- Don't assume others know about the case (especially for initial assessments)
- Don't use jargon
- Don't be obsessed by the running record
- Don't write as you speak
- Don't do process recording