

Special Inspection – Implementation of Safeguarding Arrangements

Pembrokeshire County Council

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The team who delivered the work comprised Jane Holownia, Steve Barry, Rod Alcott, Ena Lloyd and David Rees. Due largely to external review, the Council is now more aware of safeguarding issues and has made some positive changes, but by failing to respond with sufficient speed and rigour it failed in its duty to make arrangements to secure continuous improvement.

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Statement by the Auditor General

- 1. This report sets out the results of my special inspection of Pembrokeshire County Council (the Council) under Section 21 of the Local Government (Wales) Measure 2009 (the Measure). The Measure requires me to mention any matter in respect of which I believe, because of the inspection, that the Council is failing to comply with the requirements of Part 1 of the Measure (local government improvement). While my inspection has not led me to question the Council's co-operation with the Board or the potential that exists, it has identified serious and on-going concerns. Therefore, in respect of the Council's arrangements for improving safeguarding, I have concluded that the Council failed in its statutory duty to make arrangements to secure continuous improvement.
- 2. I am aware that, in the period since the completion of my inspection, the Chair of the Pembrokeshire Ministerial Advisory Board wrote to the Leader and Chief Executive on 11 October 2012 giving an 'overall positive report' of the position. The Chair's letter highlighted the Council's co-operation with the Board and indicated the Board's view that there was the potential for major change. I am also aware of recent changes at senior management level which have the potential to support improvement. However, the Council itself recognises there is more to do to embed changes in operational practice.
- **3.** I would like to thank the Council for the open and transparent way in which members and officers have responded to my inspection. I am pleased that the Council welcomes the additional capacity afforded by continued external oversight. I will continue to offer that oversight and support in respect of the governance of key areas such as safeguarding.

Recommendations

4. To assist the Council in making the required improvement, I recommend that Welsh Ministers provide support to the Council by:

R1 Exercising their powers under Section 28 of the Measure with specific emphasis on supporting governance, scrutiny and assurance arrangements.

Background

- 5. A report¹ published by Estyn, Her Majesty's Inspectorate for Education and Training in Wales (Estyn) in August 2011 found that the quality of education services for children and young people was unsatisfactory and the Council's capacity to improve was unsatisfactory. In particular:
 - there was a systemic corporate failure to respond sufficiently to safeguarding issues;
 - the quality of information that officers shared with elected members did not enable them to challenge the performance of services and schools sufficiently;
 - performance management in the past had not been effective in securing improvements against certain key indicators; and
 - value for money was inadequate.
- 6. Also in August 2011, Estyn and the Care and Social Services Inspectorate in Wales (CSSIW) published a report² following a joint investigation of the handling and management of allegations of professional abuse and arrangements for safeguarding and protecting children in education services by the Council. Regulators assessed the handling of a sample of 25 case files held by the Council's social services, education services and human resource service. This report identified significant failures in arrangements, which were unknown to the Council and concluded:
 - there had been a lack of oversight by elected members and officers at the most senior level within the authority of the management and handling of cases of alleged professional abuse in education services;
 - the absence of effective governance in relation to safeguarding and protecting children reflects the specific failures within the culture of the authority as a whole; and
 - the shortcomings were longstanding, systemic, and indicative of the deep-seated nature of these problems and failings within the authority.
- 7. In October 2011, because of the significance of failings, the Welsh Ministers appointed the Pembrokeshire Ministerial Board (PMB). The PMB's role was to assess the sustainability of change and the long-term prospects for improvement at the Council, and to advise Welsh Ministers on progress and on the need for any further actions.

¹ A report on the quality of local authority education services for children and young people in *Pembrokeshire County Council*, Estyn, June 2011 (published August 2011)

² Joint investigation into the handling and management of allegations of professional abuse and the arrangements for safeguarding and protecting children in education services in Pembrokeshire County Council, Estyn and CSSIW, August 2011

- 8. Issues identified in the Estyn and CSSIW investigations led to a wider review of inter-agency practice in Pembrokeshire. In November 2011 Estyn, CSSIW, Her Majesty's Inspectorate of Constabulary (HMIC), Health Inspectorate Wales (HIW) and Her Majesty's Inspectorate of Probation (HMIP) published their findings in a joint report³. The report recognised some positive aspects of inter-agency working but highlighted failings in arrangements, which meant they did not adequately safeguard and protect children. In particular, the report identified a lack of strategic leadership 'which contributed to a collective culture in which it was difficult for any of the individual agencies involved to discharge their responsibilities for safeguarding and protecting children effectively in cases of alleged professional abuse'.
- **9.** Following the publication of critical reports from inspectors over the period June to November 2011, the Auditor General undertook a special inspection of corporate governance arrangements at the Council which he reported in January 2012⁴.
- **10.** He concluded that whilst the Council displayed some positive attributes in relation to its culture and operating environment, it needed to:
 - improve political and managerial oversight and appropriately hold people to account;
 - clarify the decision making and governance responsibilities of members and senior officers; and
 - promote effective challenge and put quality assurance arrangements in place to ensure that mechanisms of management and supervision were effective.

Recent activity

- **11.** In July 2012, because of continuing concerns, the Minister for Education and Skills issued a formal Direction requiring the Council to comply with any instructions the Chair of the PMB considered reasonable to ensure it discharged its safeguarding duties under Section 175 of the Education Act 2002.
- **12.** Regulators undertook follow-up work between May and September 2012:
 - CSSIW and HMIC reviewed a sample of case files relating to alleged professional abuse over the period April 2011 to April 2012;
 - the Wales Audit Office reviewed the Council's Human Resource Service records relating to those professionals who were the subject of the allegations; and
 - Estyn and CSSIW undertook unannounced visits to four schools in July 2012 to check arrangements for behaviour management.

³ Joint inspectorates' review of inter-agency arrangements and practice to safeguard and protect children in Pembrokeshire, CSSIW, Estyn, HIW, HMIC, HMIP, November 2011

⁴ Special Inspection, Pembrokeshire County Council, Wales Audit Office, January 2012

- 13. More detail about the results of these inspections is presented later in this report. The conclusions of the reports have much in common. They all found evidence of new procedures being in place, and some examples of positive practice. However, they also identified that implementation of policy and procedure was slow and inconsistent, with limited positive impact. Some of the failures were significant. For example, the inspections identified a lack of clarity about the practical application of positive handling polices (what a teacher can or cannot do when having to physically intervene) and inconsistent, sometimes inadequate, handling of cases of alleged professional abuse. Twelve months after regulators had first identified these issues, the Council had still not secured effective safeguarding arrangements. Quality assurance processes remained insufficiently robust to reliably identify inconsistencies and other weaknesses and drive improvement.
- 14. The Auditor General planned to re-inspect the Council in October 2012 to assess progress in meeting the recommendations made to the Council in January 2012. Concerns by Welsh Ministers about the implementation of change at the Council led to a request that the re-inspection be undertaken earlier. This re-inspection specifically sought to determine whether the Council has made sufficient progress in addressing the need to improve the management and governance of safeguarding.
- **15.** The Council has experienced significant change over the past 12 months. Local Government elections led to the formation of a new administration in May 2012. There is a new Leader, a new Cabinet Member with responsibility for Safeguarding, and changes in chairs of overview and scrutiny committees. Elected members have sought to secure a degree of continuity by appointing colleagues with some experience of safeguarding matters to senior roles although most are new to their particular roles and responsibilities with regard to safeguarding. During the election campaign, members appointed a new Director of Social Services. The retirement of the Director of Education was announced in late September 2012. From 16 November 2012, the Council transferred responsibilities for education and children to the new Director of Social Services who assumed his full-time duties with the Council in September 2012.
- **16.** Since the completion of our interviews during August 2012, the Council has advised us that further progress has been made in a number of areas:
 - The new Director of Social Services beginning full-time working and taking over the Director of Education and Children's Services' safeguarding responsibilities at the end of September 2012.
 - A new Head of Internal Audit being appointed with a remit to revise the Internal Audit work programme so that greater attention is given to safeguarding matters.
 - Securing additional capacity, to help increase the pace of the safeguarding improvement agenda.
 - Securing an agreement with Carmarthenshire County Council to implement a shared service for School Improvement.

- The commissioning of a 'safer schools' quality assurance framework. Recruiting additional social workers.
- Working positively with the PMB and in the process of agreeing a risk-based approach to monitoring progress which deals more effectively with the underlying causes of the weaknesses identified in 2011.
- **17.** These changes have the potential to address many of the weaknesses identified provided the focus is on delivery and assurance rather than on process.

Conclusion

- **18.** We found that due largely to external review, the Council is now more aware of safeguarding issues and has made some positive changes, but by failing to respond with sufficient speed and rigour it failed in its duty to make arrangements to secure continuous improvement.
- **19.** We reached this conclusion for the following reasons:
 - as a result of external reports the Council has introduced policies and procedures that have heightened awareness of safeguarding but has not addressed the underlying causes of failings;
 - the Council is acting too slowly to address serious issues such as the use of timeout rooms, and is not implementing new policies and procedures effectively; and
 - the Council has made little progress since January 2012 in strengthening the challenge and assurance role of members.

As a result of external reports, the Council has introduced policies and procedures that have heightened awareness of safeguarding but has not addressed the underlying causes of failings

- **20.** The inspection reports undertaken during 2011 referred to a range of issues including the need for the Council to 'undertake a comprehensive and rigorous evaluation of all safeguarding work within the education department and its schools, including taking urgent steps to remedy deficiencies in the governance and management of safeguarding, including associated functions in human resources⁵'. Regulators also concluded that the shortcomings in arrangements were longstanding and systemic being indicative of the 'deep-seated nature of these problems and failings within the authority⁶'.
- **21.** In her written statement of 11 August 2011, the Welsh Government Deputy Minister for Children and Social Services had indicated, This is a failure in delivery. More policies, more regulations, more guidelines and more inspection are not the answer.'
- 22. In August 2011, the Chief Executive set up the Chief Officers Safeguarding Panel with the specific remit of receiving key monitoring reports, including updates on new allegations of professional abuse, reports on on-going investigations, and compliance reports in respect of Criminal Records Bureau (CRB) checks and references. The panel comprised directors and heads of central units and meets on a six-weekly basis.
- 23. Elected members considered inspectorates' reports published in August 2011 at an Extraordinary Meeting of Council on 6 September 2011. At this meeting, the Leader explained changes being made to the political structure to strengthen member accountability by establishing a specific Cabinet role for Safeguarding. He also announced the establishment of a Member Accountability and Improvement Board (later known as the Safeguarding Accountability and Improvement Board (SAIB)). The Council adopted its Safeguarding Children Improvement Plan (SCIP) at this meeting. Minutes of a Council meeting of 20 October 2011 show questions from only a small number of members challenging some of the underlying safeguarding issues. Answers to those questions indicate a focus on policy and do not focus on the causes of failure and how they might be addressed in the SCIP.

⁵ A report on the quality of local authority education services for children and young people in *Pembrokeshire County Council*, Estyn, June 2011

⁶ Joint investigation into the handling and management of allegations of professional abuse and the arrangements for safeguarding and protecting children in education services in Pembrokeshire County Council, CSSIW and Estyn, August 2011

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- 24. The Council was aware of the issues emerging and had prepared its SCIP and submitted the plan to Welsh Ministers, by 9 September 2011, within the agreed timescale. By June 2012, the Council considered it had completed the actions set out in the SCIP through its Safeguarding Improvement Programme, which was structured in the areas of:
 - Human Resources led by the Head of Human Resources
 - Democracy and Accountability led by the Head of Policy and Performance
 - Local Safeguarding Children Board Review and Professional Abuse led by the Director of Social Services
 - Safeguarding within Education Services led by the Director of Education
- 25. The SCIP's prime focus was on addressing administrative and procedural weaknesses. We recognise that all of the actions in the SCIP were necessary, and that there was a need for the Council to ensure it had appropriate policies and procedures in place. The dissemination of policies and procedures and development of guidance on roles and responsibilities has had the positive benefit of heightening awareness of safeguarding issues across the Council.
- **26.** However, prior to preparing and implementing the actions within the SCIP, the Council did not ask some fundamental questions about whether potential underlying factors such as an emphasis on protecting reputation or an overreliance on trust which might be hindering safeguarding.
- 27. Our review of the Council's responses to the 2011 and 2012 inspectorates' reports together with our review of the SCIP identified a task-oriented approach, which involves listing the issues in reports along with listing the actions the Council plans to take in relation to them. However, the Council developed its action plans, policies and procedures, without first arriving at a full understanding of the reasons for the failures identified by regulators. The Council appears to be overly dependent upon external scrutiny to fully identify the root causes of issues and the action necessary to ensure necessary change.
- 28. We invited elected members, staff and chairs of governors in Pembrokeshire to provide their views on the development of safeguarding arrangements at the Council. We were encouraged to have received 106 responses from staff indicating the importance that staff attached to safeguarding arrangements. However, given the importance of their role in safeguarding, it was revealing that only 10 of 60 members responded to our survey. We comment further on this in paragraph 80. Just over half of the staff below senior officer level who responded felt there had been improvement in terms of heightened awareness of safeguarding and improved practices in respect of CRB checks and the establishment of the Chief Officers Safeguarding Panel. However, 41 per cent felt there was only partial improvement in awareness and seven per cent considered there had been little improvement. Those who felt there had been partial or little improvement cited a number of issues. Some referred to the need to address what they perceived as a 'denial' of problems by some senior managers. Others referred to an emphasis on paperwork rather than informing staff at operational level of what is acceptable and unacceptable behaviour. Senior officers and the small

number of elected members who responded cited the need for more effective co-operation between education and social services.

- 29. An area where there is evidence of change is that temporary suspensions are now used pending investigations of alleged professional abuse. Follow-up work by CSSIW and HMIC published in September 2012 recognised some improvement in relation to the handling of professional abuse allegations but also found management of cases to be inconsistent. The Council has sought to strengthen these arrangements by producing improved guidance for the meetings that consider such allegations. Meetings convened to discuss such allegations are known as 'strategy meetings' and involve council officers as well as other key stakeholders such as the police. The Council has given more seniority to the social services manager who chairs the meetings that consider these cases but the recent follow-up work by CSSIW and HMIC concludes this manager does not hold sufficient authority to be effective in this role.
- **30.** To support sustainable change the Council needs to ensure that both staff and elected members fully understand the need for appropriate behaviour within their respective roles and are supported in demonstrating such behaviour. In April 2012, the Council and the PMB began the development of a Cross Service Action Plan (CSAP) to promote safeguarding, democratic accountability, leadership and management. This plan emphasised the need for officers and members to develop their understanding of roles and responsibilities, and set out plans for mentoring and coaching senior members to support them in fulfilling them.
- **31.** In contrast to the SCIP, the CSAP provides more insight into how change might be supported by facilitating discussion and exploring desired behaviours. The following table illustrates the way in which the CSAP covers issues in a more reliable way than the SCIP.

Exhibit 1: Comparison of the SCIP and CSAP

The CSAP has a stronger focus on embedding understanding of safeguarding issues

SCIP extract	CSAP extract
 Revise and strengthen elected member roles and responsibilities The SCIP includes a series of supporting actions which include: review and re-profile the lead member role; ensure regular meetings between lead members and senior officers include child protection issues; lead members to produce twice-yearly reports; and ensure all elected members attend child protection awareness and training sessions and include it in elected member induction. 	 Democratic Accountability; PMB to: meet senior officers to discuss roles in relation to Cabinet members; meet officers to ensure quality control training in new scrutiny practices are in place; attend scrutiny training; meet with new scrutiny support team to establish level of quality and independence; and develop a mentoring/coaching relationship with the new leader and aim to help new and reappointed Cabinet members develop challenging relationship with senior officers.

Source: Pembrokeshire County Council Safeguarding Children Improvement Plan (September 2011) and the Pembrokeshire Ministerial Board Cross Service Action Plan (April 2012)

32. Whilst the CSAP has been developed by the PMB in partnership with officers in the education service, there was little evidence to suggest the Council is integrating CSAP activity with implementation of actions in the SCIP.

The Council is acting too slowly to address serious issues, such as the use of timeout rooms, and is not implementing new policies and procedures effectively

The Council has been slow to develop guidance and engage in discussion with its professional staff, particularly about the use of 'timeout' rooms

33. It is a matter of public record that a head teacher of a Pembrokeshire school was convicted of sexually assaulting girls in his care and imprisoned in 2009. This case highlighted specific risks but subsequent inspections have found that the Council did not act promptly to provide adequate advice, guidance and support to staff to enable them to safeguard pupils. We are concerned that there is continuing evidence that the Council is slow to respond to serious safeguarding concerns.

- **34.** Questions arose about the appropriate use of timeout rooms as long ago as 2009 but action taken at the time was narrowly focused meaning the opportunity to give wider consideration of the issue was not taken. Some of the subsequent issues arising about the use of rooms, might have been avoided had this opportunity been taken to investigate any potential issues with similar rooms at all schools. The response at the time was to focus only on the particular room in question and to end its use as a timeout room. The then Director of Education commissioned an investigation of the use of this room in September 2009 which reported in January 2010. There is no evidence that having identified an issue of potential significance to safeguarding in one location, officers acted effectively to ensure that there were no similar risks elsewhere. We found no evidence that guidance on the use of timeout rooms was made available promptly and to all relevant staff following the January 2010 report.
- **35.** The need to further examine the handling of the issues relating to the timeout room in 2009 was not recognised until January 2012. The Chair of the PMB wrote to the Leader and Chief Executive in January 2012, confirming his discussion with the Chief Executive at which he had highlighted weaknesses in the Council's 2009 investigation, and the matters that should be within the scope of any further investigation. The Chief Executive commissioned an internal investigation into the circumstances surrounding the commissioning and use of this room, in particular to investigate the conduct of officers who dealt with the issue. This investigation is yet to be concluded.
- **36.** Events during May 2012 revealed that some eight months after regulators raised concerns about safeguarding practices, the Council still did not understand the nature or the extent of use of timeout rooms at its schools. Nor did it have any clear guidance or framework in place for facilitating discussion amongst practitioners about their use.
- **37.** Officers in the Council's Social Services Department raised concerns with the PMB about a room at another school in May 2012. The issue initially came to light via a chance discussion between a social worker and her manager. At this point, the Ministerial Board and the Council began further investigations into the use of timeout rooms in Pembrokeshire schools.
- **38.** Council officers visited all 68 schools to determine if such rooms were present. The former Director of Social Services then visited 18 schools where the initial visit prompted questions about the suitability or use of rooms. Interviews with Council staff and members of the PMB revealed that there was some initial disagreement about whether rooms were appropriate or not. Clear guidance about the design and use of rooms was still unavailable. The fact that such guidance was not developed when issues first arose was, in our view, a clear failure in leadership.
- **39.** Estyn and CSSIW inspectors conducted unannounced visits to two primary schools and two secondary schools at the beginning of July 2012. The purpose was to seek assurance about behaviour management in schools. Inspectors reviewed policies and procedures, discussed the use of rooms, exploring understanding of issues with staff, examined records and sought pupil views on behaviour management.

- **40.** The Estyn and CSSIW inspectors concluded⁷ that staff were generally well informed about behaviour management and had a clear understanding of how to make child protection referrals. However, inspectors identified some key failings:
 - Senior leaders were not monitoring the day-to-day implementation of policies rigorously enough so were unaware of the failings found by the inspection team. The inspectors found inconsistency in application of procedures and a lack of adequate record keeping.
 - There were weaknesses in respect of 'positive handling' policies. 'Positive handling' covers what a teacher can and cannot do when they have to intervene physically for the pupil's own safety or the safety of others. Although policies were in place, they did not give enough explanation about what could or could not be done in an emergency and staff were found to be less familiar with these policies than with their school's behaviour policy.
 - Senior officers in education were depending upon head teachers to disseminate policies and had no systematic means of checking implementation or understanding of content.
- **41.** In October 2012, a report to the Council's Safeguarding Overview and Scrutiny Committee indicated that guidance on the use of timeout/withdrawal areas and sensory rooms was now available and its implementation was scheduled for discussion at a head teachers' workshop. More than three years had elapsed since the issue first arose.

Some key safeguarding issues identified by regulators in August 2011 remained unresolved in August 2012

- 42. In August 2011, Estyn and CSSIW published a report⁸ following a joint investigation of the handling and management of allegations of professional abuse and Council arrangements for safeguarding and protecting children in education services. Regulators assessed the handling of a sample of 25 case files held by the Council's social services, education services and human resource service. This report identified significant failures in arrangements and concluded:
 - There had been a lack of oversight by elected members and officers at the most senior level within the authority of the management and handling of cases of alleged professional abuse in education services.
 - The absence of effective governance in relation to safeguarding and protecting children reflects the specific failures within the culture of the authority as a whole. The shortcomings were longstanding, systemic, and indicative of the deep-seated nature of these problems and failings within the authority.

⁷ Note of visit – Behaviour management in four Pembrokeshire schools, Estyn, July 2012

⁸ Joint investigation into the handling and management of allegations of professional abuse and the arrangements for safeguarding and protecting children in education services in Pembrokeshire County Council, Estyn and CSSIW, August 2011

- **43.** In addition to failures in oversight and governance, the report identified a broad range of operational weaknesses that included:
 - weaknesses in child protection strategy meeting processes, both in record keeping and in some instances failing to recognise wider safeguarding implications;
 - poor handling of disciplinary situations, weak risk management and a failure to use suspension as an appropriate option pending investigation;
 - poor oversight of human resource arrangements across the Council, failing to ensure safe recruitment and vetting; and
 - weak leadership by chief officers resulting in poor communication and ineffective working relationships.
- **44.** In May 2012, CSSIW and HMIC undertook a follow-up review⁹ of arrangements to assess the impact of the Council's response to the first inspection. The review involved assessing a sample of cases and the Wales Audit Office reviewed the corresponding Human Resource (HR) personnel files.
- **45.** This follow-up recognised some progress in the timeliness of referrals and initial strategy meetings; the quality of social services and the police initial responses to allegations; outcome strategy meetings being routinely convened and a recognised need to offer advocacy and an initial assessment of need. However, it also identified a range of outstanding issues and slow progress in key areas of case management.
- **46.** It concluded that the Council had not developed monitoring, quality assurance and accountability arrangements effectively to ensure sufficient capacity to deliver services or provide assurance that safeguarding practice was improving. In particular, the follow-up concluded:
 - the plethora of activity by the Council had not supported robust analysis of information or a clear line of sight on the practice needed to secure improvement;
 - monitoring, quality assurance and accountability arrangements had not been developed effectively;
 - implementation of new policies had not been underpinned by multi-agency training to ensure that all key stakeholders were clear about their contribution to strategy meetings and their post-investigation responsibilities;
 - the poor quality of strategy meeting minutes identified previously had not been improved and continues to impact on safeguarding practice; and
 - important lines of oversight and communication in relation to safeguarding between education and social services still needed significant improvement.

⁹ Joint Review of Arrangements to Safeguard Children Subject to Alleged Professional Abuse in *Pembrokeshire*, CSSIW and HMIC, September 2012

- **47.** The Wales Audit Office review of the corresponding HR documentation and processes, conducted in June 2012, concluded that the Council did not yet have sufficiently robust information and quality assurance systems in place to ensure that it had proper management and oversight of process and outcomes in relation to cases of alleged abuse by a professional. In particular, the SCIP had included an action to 'issue a direction for comprehensive personnel information regarding all staff working in schools to be stored on a central personnel file, including information on any grievance or personnel issues'. The Council reported this action as 'complete' by September 2011; the following paragraphs illustrate that no assurance can be provided from issuing the direction.
- 48. Prior to the Wales Audit Office file review, the Council had conducted its own review of each personnel file in relation to current CRB checks and references. The Council reported that pre-employment (and thereafter renewal) CRB checks and adequate references were in place for employed staff and volunteers. The Council considered monitoring arrangements were adequate and that they provided the Council with assurance on these aspects of staff employment. The Wales Audit Office team found that the Council is ensuring that pre-employment (and thereafter renewal) CRB checks and adequate references are in place for employed staff and volunteers. The team further found that there are adequate monitoring arrangements in place to provide the Council with assurance on these aspects of staff employment. The Council arrangements in place to provide the Council with assurance on these aspects of staff employment. The Council arrangements in place to provide the Council with assurance on these aspects of staff employment. The Council now has a policy on who may provide organisational references
- **49.** Feedback provided through workshops we held with staff indicated that there may be some inconsistency in the understanding of the application of CRB procedures. Specifically, whilst some directorates believed they must apply for a separate CRB check for each post a single member of staff holds, other directorates apply for only one CRB check per staff member, irrespective of the number of posts held. The Council told the Wales Audit Office team that it has corporate control over the CRB application process. It may wish to provide managers with clarification on this to encourage a consistent understanding.
- **50.** In order to assist the process of providing references, the HR department developed a new form headed: 'Summary of child protection allegation/concern to be placed on personnel file' which it introduced in September 2011. Generally, where these forms were present in the personnel files reviewed, we found that they recorded some details of relevant child protection allegations but, with a small number of exceptions, they only recorded those made from around September 2011 onwards.
- **51.** We conducted extended testing in order to obtain a more complete and up-to-date record of the corporate management of those cases where corporate personnel files were found to be incomplete. The Wales Audit Office review team found some of the relevant documents/evidence located in at least three different locations, including:
 - the HR electronic personnel system;
 - directorate local personnel files; and
 - local directorate databases to which other corporate managers do not have ready access.

- **52.** Even allowing for discretion in how a particular allegation is managed, the approach to, and the rationale for, the management of cases was not always fully documented. In those cases reviewed where child protection allegations had been made against professionals, the personnel files did not always contain justification for the course of action adopted, nor was it always recorded who made the decision on, for example:
 - whether an employee should be suspended or subjected to a disciplinary investigation;
 - who completes a risk assessment when a decision is made not to suspend a professional whilst an investigation takes place; and
 - why employees against whom a series of similar allegations had been made were allowed to remain in post.
- **53.** The Council's intention was that the HR function should capture data relating to safeguarding in terms of CRB and reference checks. Education and Children's Services and Social Care are expected to provide updates to HR on the number and progress of the management of professional allegations received. However, review findings indicate that there is no single corporate source of current detailed information on an employee and the current status of some cases could not be identified from the personnel files alone. It was therefore more difficult to track the corporate management of safeguarding allegations.
- 54. In summary, follow-up work undertaken by regulators during 2012 has identified:
 - significant issues remain unresolved;
 - there is inconsistency in the application of policies and procedures; and
 - management arrangements to drive improvement are reactive and inadequate.

Social services and education are not working effectively together to ensure the implementation of better safeguarding arrangements

The Council has not sufficiently addressed collaboration arrangements between 55. internal stakeholders. Some members and officers we interviewed referred to a historic and continuing, 'disconnect' between the education service and social services. Whilst we did find examples of education and social services staff working together effectively at operational level, we also identified tensions between these services. Some tensions might be expected, for example, because the heightened awareness of safeguarding issues has led to an increased number of referrals from education to social services. However, we also found evidence suggesting more deep-seated 'silo' working. For example, social services staff cited a referral process being piloted in two schools without sufficient consultation with social services staff. Whilst social services saw potential benefits of the new process, their lack of involvement at the pilot stage would certainly hinder implementation of the process. The retirement of the current Director of Education and Children's Services led to a transfer of responsibilities to the new Director of Social Services in November 2012 which the Council hopes will support improved collaborative working between these services.

The Council has made little progress since January 2012 in strengthening the challenge and assurance role of members

- **56.** The Auditor General's special inspection in January 2012 arrived at a number of conclusions about the governance of the Council:
 - the Council had a history of stable management, good financial stewardship, and a steady, incremental approach to improvement;
 - a culture of mutual respect and trust existed between most Councillors and officers, leading to productive working relationships;
 - a lack of clarity and understanding in relation to some roles and responsibilities, along with some lack of transparency, meant that effective challenge was not a consistent feature of governance; and
 - an overreliance on informal management approaches had weakened accountability and led to some complacency and exposure to risk.

The Council has begun to address these issues.

- **57.** The recommendations made in January 2012 are shown in Appendix 1. They can be summarised as a need for the Council to:
 - improve political and managerial oversight;
 - appropriately hold people to account;
 - clarify the decision making and governance responsibilities of members and senior officers; and
 - promote effective challenge and put quality assurance arrangements in place to ensure that mechanisms of management and supervision were effective.
- **58.** We reviewed Council documents, including minutes of the Council, Cabinet and Overview and Scrutiny meetings. We interviewed: the Leader, the Cabinet Member for Education and the Welsh Language, the Cabinet Member for Safeguarding and Children's Services, the former Leader, the Chair of the Children and Families Overview and Scrutiny Committee and the Chair of the Safeguarding Overview and Scrutiny Committee.
- **59.** We invited all elected members to respond to a short questionnaire or to contact the inspection team to arrange an alternative way of providing their views. Invitations were also made to officers, head teachers and chairs of governors to respond to the same questionnaire. We conducted interviews with the Chief Executive, Assistant Chief Executive, the current and former Director of Social Services, the Director of Education and Children's Services and senior managers and operational staff in the education service and social services.
- **60.** We looked for evidence that roles were clearly understood by senior members and senior officers, that roles were being discharged effectively, and that information and quality assurance processes were available to support members in the effective discharge of their roles.

- **61.** We recognise that following the local government election in May 2012 a number of the current senior members are relatively new to their role, and therefore have had limited opportunity to demonstrate how effectively they are discharging their new roles. At officer level, however, there has been a degree of stability that should have enabled the development of arrangements for quality assurance and challenge. Officers should have established systems for assuring quality (including unannounced visits, observation or file checks) and be presenting members with improved information about the impact of the revised processes and procedures.
- **62.** Since his election in May 2012, the new Leader has taken specific steps to demonstrate his commitment to addressing issues by:
 - securing elected member support for the establishment of a new Safeguarding Overview and Scrutiny Committee;
 - retaining the Cabinet role for Safeguarding and Children's Services;
 - engaging with the Children's Commissioner for Wales to draw on his specific expertise; and
 - giving an unreserved apology in relation to practices at the Pupil Referral Unit in 2009.

The Council has acted to clarify the respective roles and responsibilities of members and officers but does not have a robust approach to ensuring they are discharged effectively

- **63.** The Council has improved clarity about the roles and responsibilities of elected members and officers. The Council has introduced specific responsibilities for safeguarding at member level. It has introduced a Cabinet position for Safeguarding and Children's Services and has a Safeguarding Overview and Scrutiny Committee. The Council has also taken steps to make specific responsibilities and accountabilities clearer at officer level. The majority of respondents to our survey believed they were clearer about their own role in relation to safeguarding and that their colleagues also had a better understanding of their role.
- **64.** However, the Council is not integrating delivery of safeguarding responsibilities and roles into the Council's appraisal system. We could find no officers for whom safeguarding performance was a key element of their appraisal nor could we find consistent implementation of what we had been advised was a corporate HR appraisal system.

Elected members have not challenged plans or their implementation effectively

- **65.** Although the Council submitted an action plan by the date required by Welsh Ministers, there was no pause to reflect on the plan's content to seek assurance that actions proposed would be sufficient. In particular, minutes of the Council meeting of 6 September 2011 provide little evidence that the Council gave sufficient regard to the 11 August 2011 written statement by the Welsh Government Deputy Minister for Children and Social Services who indicated, 'This is a failure in delivery. More policies, more regulations, more guidelines and more inspection are not the answer.'
- **66.** The Council set up the SAIB at its 6 September 2011 meeting and the SAIB held its first meeting on 14 September 2011. This Board was made up of the leaders of all political groups, Cabinet members and the Chair of Children and Families Overview and Scrutiny Committee. The majority of the elected members on this Board are currently in key positions in respect to safeguarding and its scrutiny, and will thus have accumulated a degree of knowledge of the issues facing the Council. The role of the SAIB was to set the direction and monitor the progress of the implementation of the SCIP and report to Council. The SAIB was not a formal committee of the Council so an arrangement was put in place that the notes of its meetings would be circulated to the Children and Families Overview and Scrutiny Committee.
- **67.** The SAIB operated until June 2012 when it signed off the SCIP as complete confirming that responsibilities were in place at Cabinet level and Safeguarding Overview and Scrutiny Committee for the reporting and monitoring of safeguarding activity.
- 68. In the period September 2011 to June 2012 Council records show that there were six meetings of the Children and Families Overview and Scrutiny Committee. The September meeting received the Estyn and CSSIW reports. The SCIP was also presented minutes indicate the focus of discussions was on the implementation of the plan.
- **69.** There is no public record of two of the six meetings of the overview and scrutiny committee. We are therefore unable to determine whether members challenged the content of the SCIP or the information they were being provided. In the committee's meeting held in November 2011, consideration of the SCIP was deferred because the version presented was out of date. Records do not show the SCIPP being considered again until 19 June 2012. Reports to the committee on the SCIP all indicate the proportion of actions completed in relation to the target timescales. However, they contain no evidence of qualitative analysis and minutes do not indicate questions from members seeking assurance of the satisfactory implementation of change.

70. In June 2012, the Leader of the Council wrote to Welsh Ministers providing a range of information, which he believed, demonstrated that the Council was making good progress in addressing safeguarding issues. The 'completion' of the actions in the SCIP, reference to HR procedures being strengthened and reflecting 'best practice', and the levels of scrutiny and challenge by members were all cited as evidence to support his view. The findings presented in this report show that such assertions were not based upon reliable evidence and there is a need for all members to be more challenging when presented with information by their officers.

Member training is much improved but information provided to members is still inadequate, and scrutiny and challenge are still not sufficiently robust

- **71.** The majority of elected members we interviewed during this inspection recognised the need to improve their level of challenge and scrutiny but acknowledged that they needed particular support in developing basic scrutiny skills as well as being equipped to know the correct questions to be asking in specialist areas such as safeguarding.
- 72. In the period June to August 2012, the Council has provided a high proportion of members with training to support their overview and scrutiny role 51 members attended basic training, eight members attended chairing skills training and 42 attended questioning skills training.
- **73.** We recognise the importance of this training to the future performance of members in their roles and the increased focus on training is encouraging. However, we have not found evidence that its impact is sufficient to secure the levels of improvement needed, particularly without similar improvements to the information provided to members.
- 74. Two meetings of the Safeguarding Overview and Scrutiny Committee have been held since the May 2012 elections. At the 15 October 2012 meeting, members were presented with a detailed agenda for that meeting which included a draft framework for safeguarding in education. This document set out a series of actions and proposed measures by which members could judge the effectiveness of the Council's actions. Some of these proposed measures were limited to confirmation that reports or mechanisms were in place. There were few measures that would provide assurance of quality and allow members to challenge more effectively.
- **75.** In many respects, recent reports give no more assurance to members than the report which was presented to members of the Child and Families Overview and Scrutiny Committee on 20 March 2012, assuring them, erroneously in our view, that completion of 70 per cent of the actions in the SCIP illustrated 'the Safeguarding Improvement Plan evidenced real and sustainable improvement in performance'.

- **76.** The Safeguarding Overview and Scrutiny Committee also received a summary of the recommendations in the Estyn note of the visits to four schools. Although the summary report noted that the full report was on the Estyn website and included the website address this did not provide members with easy access to the report. The full report contained considerably more detail than that which appears in the summary produced by officers giving greater insight into the issues from which members could have developed their own questions.
- 77. It is our view that members are still not getting the information they need to challenge whether the Council's actions are making a significant difference to safeguarding. Early reports to members focused on the completion of actions in the SCIP, 'closing' the report when actions were classified as complete. The reports provided members with information about the progress in completion of tasks, but did not provide information on the context, effectiveness and impact of the new arrangements. Recent reports provide relevant, more contextual information for members and describe processes officers are implementing. The reports describe actions but the lack of qualitative measures or effective testing of revised arrangements by the Council means the impact is unclear. Records of recent meetings do not indicate that members have been actively seeking improved information to allow them to evaluate the effectiveness of the Council's actions in relation to safeguarding.

Documentation has been produced to clarify roles and more information is provided to members but little change has been secured to address the issues identified in January 2012

- **78.** Documents produced since January 2012 enable the Council to show that it has clarified the responsibilities of senior members and senior officers. Most of the Councillors we spoke to referred to improvements in the provision of information to elected members. The Council was, however, starting from a very low base in terms of what was routinely provided to members, and some of the examples of improvement we were given, such as improved information from officers about what is happening in a ward would be considered commonplace elsewhere.
- **79.** This report shows that the Council has a considerable way to go before it can demonstrate it is being effective in:
 - providing robust political and managerial oversight;
 - appropriately holding people to account;
 - delivering effective challenge; and
 - putting quality assurance arrangements in place to ensure that mechanisms of management and supervision are effective.

Members demonstrating an active interest in driving improvement are in a minority

- **80.** The response of members to our short questionnaire about safeguarding was disappointing. Only 10 out of a possible 60 members responded to our invitation to provide their views. Given the extent of external scrutiny of the Council, we had expected a far higher response rate. The questionnaire gave elected members the opportunity to comment on progress over the past year, comment on their understanding of their responsibilities, to identify what they felt had improved and what they felt remained to be done. The low response rate means we cannot provide reliable feedback about member views and leads us to conclude that members either do not have a clear understanding of the importance of safeguarding or do not give their role in safeguarding the priority it requires.
- **81.** Those elected members that acknowledged the need for improvement and responded to our invitation to provide their views are in the minority. Cabinet and Overview and Scrutiny members are currently faced with an increased flow of information and new plans, and as the section above demonstrates, there is some improvement to information from a very low base. But these documents still lack a focus on outcomes and measures by which members can be assured that the necessary changes are being achieved and will be sustained. In the absence of clear and robust information, members require a high degree of motivation to challenge reports and require officers to provide them with sufficient and reliable information that allows them to evaluate service provision and challenge ways of working. In our view, few members demonstrate the motivation or capacity to do so.

Appendix 1

Recommendations made by the Auditor General, January 2012

- R1 Clarifies, in an easily understandable format, governance and decision-making roles, specifically of the:
 - Cabinet
 - Scrutiny committees
 - Corporate Governance/Audit Committee
 - Corporate Management Team
- R2 Ensures that appropriate documentation is kept of meetings, proposals and business cases and decisions, and made readily available, to provide assurance that decision making is undertaken appropriately and transparently.
- R3 Takes steps to ensure that Councillors are clear about what is expected of them and are effectively supported in whatever role they perform; including by:
 - setting out role descriptions;
 - delivering role-specific training;
 - evaluating effectiveness of Councillors in their roles; and
 - considering how scrutiny can be better supported.
- R4 Sets out clearly, in a policy or protocol, what information Councillors can expect to receive, its frequency and the methods of communication.
- R5 Ensures that scrutiny programmes are aligned to the strategic business of the Council; to include:
 - more frequent scrutiny of budget and performance;
 - scrutiny of corporate policy and practice;
 - overview and scrutiny of risks;
 - overview and scrutiny of equalities and diversity policy and practice; and
 - publishing a Cabinet forward work programme.
- R6 Continues with amendments to the Constitution to improve openness, transparency and to promote effective challenge.
- R7 Puts quality assurance arrangements in place to ensure that mechanisms of management and supervision are effective.

Special Inspection, Pembrokeshire County Council, Wales Audit Office, January 2012

Appendix 2

Methodology

This appendix sets out the scope of our special inspection and the methods we used in the course of our work.

Our key question was whether the Council was making sufficient progress in addressing the need to improve the management and governance of safeguarding in schools. To answer this question, we also asked:

- Have members and senior managers demonstrated effective leadership in dealing with the concerns raised by CSSIW, Estyn, the Wales Audit Office and the PMB?
- Has the Council effectively managed the improvements and change required?
- Are there clear lines of accountability and reporting arrangements that provide assurance that safeguarding duties will be effectively discharged and evaluated in the future?

In carrying out the special inspection, we undertook various activities, both desk-based and on-site fieldwork at the Council.

Document review

We undertook a review of documentation relevant to the governance and management of safeguarding. This included minutes of Council meetings, a range of Council plans, policies and procedures and reports produced by the Wales Audit Office and other regulators.

Meetings and interviews

During our fieldwork, we carried out semi-structured interviews with:

- Councillors (cabinet, scrutiny and non-executive)
- Members of the Corporate Management Team
- Members of the PMB
- Heads of service
- Operational staff involved in the delivery of, and support to, services
- Trade union representatives

As well as prearranged interviews, we also provided all Councillors and staff with the opportunity to meet one of the inspection team to discuss any issues that they wanted to bring to our attention.

Survey

In order to receive as many views as possible from those wishing to contribute we arranged an on-line survey and sent a link in e-mails to Councillors, officers, head teachers and Chairs of School Governors. We also provided a free-post address for those who did not wish to or were unable to complete the survey on-line. Respondents were able to remain anonymous if they so desired.



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