

Electronic Case Files and Case File Recording Policy Version 3.00 August 2015

Version Control

Document History

Version	Date	Author	Change History
1.00	Nov 2006	Phil Linguard	Reviewed and approved version
2.00	Nov 2007	Phil Linguard	Reviewed and approved version
2.01	Nov 2008	Michelle Peel	Revisions
2.02	08/01/09	Michelle Peel	Case File Closure and Archival Arrangements added.
2.03	23/04/09	Michelle Peel	CAF information inserted and CAF template added to Appendices
2.04	November 2012	Cathy Rooney	Comments received from managers
2.05	December 2012	Cathy Rooney	Chronology; Liquid Logic Section updated by Neil Forrester
2.06	January 2013	Cathy Rooney	Chronology; Updated numbering and added quick guides to the back
2.07	February 2013	Cathy Rooney	Chronology; Final Version presented to DCS Safeguarding Governance Group
3.00	19/02/13	Michelle Peel	Issued version with updated version control, references and formatting.

References

Anon. (2012) ICT Vision and Strategy 2012-2015. [online] Trafford Council: Business Change and ICT. Available at: http://intranet.trafford.gov.uk/yourtrafford/ICT/StrategiesPoliciesAndPlans/Strategies/VisionAndStrategy.asp

Family Justice Council (2008) Re Baby P [online] Available at:

http://www.judiciary.gov.uk/JCO%2FDocuments%2FFJC%2FPublications%2FBaby+P.pdf

Laming. (2003). The Victoria Climbié Inquiry: Report of an inquiry by Lord Laming. [online] Available at: http://www.dh.gov.uk/prod consum dh/groups/dh digitalassets/documents/digitalasset/dh 110711.pdf

Ministry of Justice (2008) The Public Law Outline: Guide to Case Management in Public Law Proceedings. [online] Available at: http://www.judiciary.gov.uk/Resources/JCO/Documents/Guidance/public law outline.pdf

Munro Review of Child Protection (2011)

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/175391/Munro-Review.pdf

Document Reviewers

No.	Name	Role	Date	Issue
1	Phil Linguard		24/11/06	1.00
2	Michelle Peel	Implementation Officer	Nov 2008	2.00
3	Michelle Peel	Implementation Officer	08/01/09	2.01
4	Michelle Peel	Implementation Officer	23/04/09	2.02
5	Cathy Rooney	Head of MARAS	November 2012	2.03
6	Charlotte Ramsden	Joint Director	December 2012	2.04
7	Ged Crowther	HoS CiC	December 2012	2.04
8	Katherine Mackay	HoS Area Team South	December 2012	2.04
9	Chris Reilly	Acting HoS MARAS	July 2015	3.00

Document Approvals

No.	Name	Role	Date	Version
1	Deborah Brownlee	DCS (via the DCS Safeguarding	1 st Feb 2013	2.0
		Governance Meeting)		
2	John Pearce	DCS (via the DCS Safeguarding		
		Governance Meeting)		

Next Review

Date	Service
August 2016	DCS Safeguarding Governance Group

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Case File Recording

Principles and Purposes of Case File Recording

Lord Laming's Report (2003) identified several key recommendations, which require social workers to maintain accurate, informed and up to date case recordings. The CYPS has a clearly stated belief that good case recording is central to good care practice.

The Munro Review of Child Protection (2011) stated that:

Recording is a key social work task and its centrality to the protection of children cannot be over-estimated. Getting effective recording systems in place to support practice is critical.

The Council has an ICT Vision and Strategy (2012) which complements the general policy on case recording.

Quality recording is central to good practice within Children and Young People's Service. It promotes focused work, assists continuity when a variety of personnel are involved and is an essential monitoring tool for managers. Effective recording supports partnerships with service users and carers.

All recording should be:

- Non-discriminatory
- Non-judgmental
- Accurate
- Timely
- Retrievable
- Secure
- Legible
- Complete
- Fit for purpose
- Electronically authorised on the Integrated Children's System (ICS) by Line Manager

Where, What and When to Record?

All Running Reports, Child and Family Assessments (including all personal details, significant events), Meetings, Dates of panel decisions, Court Hearings etc must be recorded on ICS.

All pages of documents that are signed by parents, carers or professionals without access to the ICS system should be uploaded.

Discussions with the manager, deputy manager, area team leader or senior practitioner about a service user, whether within or outside of supervision, and **any decisions** made as a result of this conversation, **must be recorded** in the running reports, using 'Case Discussion with Team Manager' as case note type.

Recording should take place in the following circumstances:

Home and Office Visits	This should include: -
	Date and place of visit.
	Who was present during the visit?
	3. Clear reasons for the purpose of the visit.
	4. Arrangements for monitoring adults identified as a
	Risk to Children and regulating their contact with
	vulnerable children (S47 investigations into contact
	with such adults to be recorded on the child's file)
	5. What information is to be gathered during the course of the visit?
	6. Failed appointments and home visits where no one
	was in should be recorded.
	7. Whether the child was seen (and if not, why not) and
	whether seen alone or not. This should be entered in red
	pen in the chronology.
	8. Analysis of progress, risks or need.
	9. Evidence for above analysis.
	10. Carers' views/ Child's views (if of sufficient age and
	understanding)
	11. Action required by whom and by when.
	12. Any use of interpretation service or an agreed
	decision to dispense with these when English is not the
	service users preferred language should be recorded.
	13. Statutory visits to Looked After Children/Young
	people should be recorded on the case note
	record and the statutory visit form must also be
	completed within the
	required timescales set out below.
	 Within the first week of a placement
	 Fourth week of the placement
	 Six weekly thereafter for the first year
	 After one year in placement every three months.
	14. Supervisory visits to Foster Carers by the Family
	Placement Officers must be undertaken every three
	months.
	15. When completing the 3 Month Summary the social
	worker must include any key points/issues as
	specified in guidance.
Telephone contacts with	This should include:-
child/family/other	1. Date of contact.
professionals	2. A summary of discussion.
	3. Action to be taken, by whom and by when.
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	I.

E-mail, Faxes & Letters 1. E-mails should be copied into case notes, including section that details the date and name of person sending the e-mail (with the exception of emails from Legal, which should be uploaded into ICS as a 'Legal Advice' document.) 2. All emails containing personal, sensitive and identifiable information should be sent securely or password protected. 3. E-mail content must be professional in nature (see 1.4) relate specifically to the child/young person or family and abbreviations for names should be used, e.g. John Smith becomes JS. 4. Faxes should be scanned and uploaded to the child's ICS file in the Documents tab. 5. Letters from third parties, that are not received electronically, should be scanned and uploaded to the child's ICS file in the Documents tab. 6. It is the social worker's responsibility to ensure that all addresses on a child's file are accurate and up to date and that any documents printed for posting are sent to the correct address. Meetings and Recording of When a strategy / discussion / core group / family support, review of CLA etc meeting is arranged the **Decisions** (All meetings held about the child/family) recording should include: -1. Date of Meeting. 2. Persons present and their designation. 3. Purpose of the meeting. 4. A summary of discussion 5. Rationale for decision/s 6. Any dissent 7. A list of action points 8. An agreed timescale 9. Who is responsible for carrying out the action? 10. Evidence that the action plan etc has been circulated to all those present or with responsibility for the action points. 11. A specified framework for reviewing the agreed actions. 12. Formal consultations with Legal Services should be uploaded to ICS, flagged as confidential and reference made to the consultation in a case note that is flagged as a significant event. **Contact Visits** 1. When a supervised contact visit is undertaken a Contact Observation Sheet must be used. This should be uploaded into the Documents section of

	the electronic case file as a 'Supervised Contact'.
	2. When completing the Three Month Summary
	Sheet the social worker must include any key
	points/issues from the Family Support Workers,
	Family Centre Workers & Outreach workers case
	notes.
Content	Recording should act as a source of relevant
	information about a child's circumstances and how
	social care has carried out its actions and duties in
	relation to a child and his or her family. All recording
	should be concise, avoid the use of jargon and
	explain any abbreviations.
	2. Sources of information should be clearly stated.
	3. There is evidence to show that information received
	is evaluated, and its relevance assessed, whenever
	possible in agreement with the person giving the
	information.
	4. Sources of information should be clearly stated.
	5. Whenever recording includes analysis, hypothesis or
	opinion (to assist in the assessment and decision-
	making processes), it must be made clear that this is
	what is being recorded. Furthermore, reasons for
	hypotheses and opinions must be stated.
	6. Case summaries must be completed by all social care
	staff every three months. The summary should be a
	brief paragraph detailing salient points and key
	issues and should be inserted into the case recording
	with '3 Month Summary' selected as Case Note type.
	Guidance as to what should be included is given in
	Appendices 10 and 14.
	7. All cases when being transferred must include an
	electronic transfer summary that includes a risk
	assessment. All case transfer documents must be
	completed securely, either via secure email or
	password protected.
	8. It is important to ensure that information/ recording
	is entered onto ICS. There is a requirement that
	there must be a recording on ICS at least every 15
	working days.

Involving and Informing Service Users/Carers and other Professionals

Electronic case files should clearly evidence that views of parents, carers and professionals have been sought, and these views should be detailed clearly within assessments and, where relevant, case notes. Assessments and forms should be distributed to relevant parties, and Strategy Meeting minutes should be distributed to professionals who do not have access to the ICS system. Pages that have been signed by relevant parties should be uploaded to the Documents tab in ICS.

It is essential that distribution of all documentation be evidenced. This can be achieved by sending reports by recorded delivery or encouraging the service user/ carer not only to sign, but also to acknowledge receipt of document.

Service users and their carers where appropriate, are always asked, and in specific circumstances told, when information about them is to be shared, and the reasons why. Further guidance around information sharing and consent can be found in the CYPS Information Sharing and Confidentiality Policy and Guidance.

Equal Opportunities in recording Practices

Case records reflect anti-discriminatory practice and demonstrate sensitivity to the needs of all in the community.

Case recording identifies special needs arising from ethnicity, race, culture, gender, age, religion, language, communication, sensory impairment, disability and sexual orientation.

Access to Case Files

Please see the Trafford Council Data Protection: Subject Access Requests Policy for guidance around access to case files.

All subject access requests are processed by MARAT.

Service users should be made aware of the policy and procedures and actively encouraged to have access to case records, and to contribute to them.

Management Arrangements

T	4. The control of the control of the first o
Team Manager	 There should be regular monitoring of all electronic and paper case files by the responsible line manager in order to ensure accountability and to give feedback to practitioners, thereby aiding professional development. Line managers should examine electronic case files on a regular basis via supervision. Two case files should be provided by social workers prior to each monthly supervision session (line managers having selected which files). This should be carried out systematically until all case files have been seen. Feedback on the quality of case recording should be given during supervision and recorded on the supervision records. Line managers must ensure that all staff have appropriate development and training opportunities to learn about good professional recording standards, children's services policies and guidance about how to put them into practice. It is the responsibility of the manager to ensure that they electronically authorise all relevant documentation.
Safeguarding Children Service	1. The electronic and paper case files will be audited on a six monthly basis by the Independent Reviewing Officers, Safeguarding Children Service. A Governance Report on the findings will be provided to the Corporate Governance Group, Senior Management Team, Children's Management Team and Team Managers and Service Managers so that practice can respond on individual, team and service-wide levels.

Review Timescales

REVIEW FLOW CHART

First Review and Unplanned Placement Change These Documents must be available electronically to Reviewing Officer 2 days SW Arranges 72 Hour Meeting before Review. Meeting considers Date for First Review Social Worker will be asked to confirm that Reviewing Officers available on mobile and Intranet other CLA documentation and Consent to Review Convened within 20 Days of Child Medical Treatment have been completed, **Becoming Looked After** signed and distributed. Second Review Second Review must be held within 3 months of the First. **CLA Review Form** Review Section will give 4 weeks notice of date Care Plan 72 Hour Minutes for all planned reviews agreed at a prior PEP * review. These documents must be available electronically Reviewing Officer 2 days before Review. Third Review Third Review must be held within 6 months of Second Review. **CLA Review Form** CHILD AND FAMILY ASSESSMENT The following documents should be made **Planning Meeting Minutes** available electronically to the Reviewing Officer Health Action Plan ** on their completion, i.e. Between Reviews PEP if Outstanding These Documents must be made available electronically to Reviewing **Court Commissioned Assessments** Officer 2 days before Review Other Commissioned Assessments Pathway Plan Final Hearing Care Plan PEP This should be at every Review hereafter ** Health Action Plan. If a statutory medical **CLA Review Form** has not been completed prior to the child's **Planning Meeting Minutes** Becoming Looked After it should be done CLA Assessment and Action Summary *** within 3 months. Children under 2 should PEP have a medical every six months and every Health Action Plan 12 months over the age of 2

Case Files

Chronologies

Background

A chronology provides a sequential story of significant events in a family's history whilst interweaving information about emotional and/or relationship difficulties. It contributes to an emerging picture, based on fact and interactions of a case – current information is understood in the context of previous information, informing professional assessment.

A chronology provides a skeleton of key incidents and events that inform the assessment of children and young people who are considered at risk or in need. A significant event is an incident that impacts on the child's safety and welfare circumstances or home environment. This will inevitably involve a professional decision and/or judgement based upon the child and family's individual circumstances.

An up to date chronology is crucial in safeguarding because it:

- Gives relevant information about previous history which may be an important indicator of risk
- Provides continuity so we can see immediately what has happened
- Presents clear accurate information
- Helps focus on key events so we can understand what is happening in the life of a child or young person
- Allows professionals to put the pieces of a jigsaw together
- Highlights risks & vulnerabilities, but also strengths and resilience.
- Patterns in social history and behaviour can be detected, events can appear insignificant in isolation but together can be identified as warning signs
- Highlights people in the child's life already known by agencies, the nature of current relationships between families and their wider social networks. This gives important information about who in the family/network may be protective and which family members may pose a risk to the child/young person
- Highlights gaps, missing details and inconsistencies that require further assessment and identification
- Lists what interventions have been tried/what has worked and what hasn't which avoids duplicating and repeating work and gives information about capacity to change
- Use as a reflective tool-for multi-agency working together-in supervision and for key decision making

Lord Laming noted the importance of a chronology in child protection in the inquiry into the death of Victoria Climbié in 2003:

"...I regard the inclusion in any case file of a clear, comprehensive and up-to-date chronology as absolutely essential..."

"...As the agency best placed to coordinate the collection of the relevant information, I regard it as the responsibility of social services to maintain the chronology, seeking the input of other agencies as appropriate..."

"Recommendation 58 Directors of social services must ensure that every child's case file includes, on the inside of the front cover, a properly maintained chronology (paragraph 6.629)"

Lord Laming (2003)

The importance of a chronology also featured in the case of Peter Connolly in 2008:

'What is lost is any holistic sense of the wider picture - the real experience of the child, the real risks which he faces. Thus, for example, in the case of Baby P any meaningful overview by way even of a simple chronology would surely have alerted social work professionals to his predicament' Family Justice Council (2008)

This guidance is aimed at producing a general chronology that is kept on case files, there may be a need to produce a more specific chronology in certain situations e.g. court chronologies

Definition

A chronology is:

- An ordered, dated record of significant events in the child's life. It can identify patterns of events, concerns, positives, strengths and unmet needs.
- A clear account of all significant events in a child's life to date, based on knowledge and information held by the agencies involved with the child and family.
- Reflects the best knowledge we have about a child's history at a point in time.

Purpose

A chronology should:

- Inform case discussion and key decision making by making it evidence based e.g. current decision making by managers may prioritise verbal presentation of information that could have gaps
- Not be an assessment but be part of assessment e.g can reveal patterns so that events aren't seen as isolated incidents
- Not be an end in itself it is a working tool which promotes engagement with people who use services and promotes multi-agency involvement

A chronology should be accurate, relying on good, up-to-date case recording. It should contain sufficient detail but not substitute for recording in the file. It will record what was done at the time. Chronologies should list events, dates etc. but also record any action which was taken at the time as well as recording when there was no action

The chronology should be regularly reviewed and analysed

To compile a chronology the practitioner must:

- Identify the key events to be recorded.
- Identify the sources of information to be used.
- Make sure what is recorded is accurate and in date order.
- Consider the significance of the events for the child and family in question.

The Public Law Outline: Guide to Case Management in Public Law Proceedings (2008) requires that a chronology be submitted along with care papers. (Pre-Proceedings Checklist).

Each child and prospective adopter's/foster carer's file should contain a chronology.

Significant points in a case when a chronology must be completed will include:

- Any stage where a case is being closed
- Referral to Child and Family assessment
- Child and Family Assessment → CIN or CP
- Strategy meeting/Section 47
- CP Conference
- Core group
- CP Review
- Moving In CP Conference
- Legal planning meetings including PLO, Issuing proceedings and Permanency Planning Meetings & Final Care Planning Meeting
- Court directs S7 /S37 reports
- Accommodation of a child or young person (as soon as is possible if unplanned)
- Statutory LAC Review
- Transfer to Leaving Care Team

What should be included in a chronology?

The lists below describes the events which will need to be included in a chronology, they are not exhaustive. There will be other significant events which will also need to be included. The decision about what other events need to be included will be based on professional judgement and managerial guidance.

Useful agency decision making information that should be in a chronology:

- Name and date of allocation of Social Workers (Recommendation 55)
- Referrals dates- reason for referral e.g. child protection enquiry, domestic violence incidents.

- Date Child and Family assessment commenced
- Date Child and Family assessment concluded
- Evidence of user involvement, including distribution of assessments, core group, CLA, Care Plans etc, e.g. when was Child and Family assessment signed and passed to parent/carer
- Court proceedings (including dates)
- Court Orders (Including dates)
- Dates of meetings (including child protection case conferences, core groups, strategy and professional, children in need, adoption, fostering, resource panels).
- Discussions with the team manager about a service user, whether within or
 outside of supervision, and any decisions made as a result of this conversation
 must be recorded.
- Significant events including birth of siblings, death of close family members, change of address, new partners, medical treatment change of school.
- All visits, recording whether the child has been seen or not and whether seen on their own.

Suggested Chronology events for children in need/child protection:

- Date of birth of child
- Family history e.g. parents' childhood, their significant life events
- Start/end dates of SW involvement
- Changes of Social worker
- Strategy meetings and S47 investigations
- Assessments
- Child's words, views, feelings and behaviour
- Significant other incidents e.g significant observation during home visits
- Concerns about specific behaviours in the family including sexual behaviour, substance misuse, domestic abuse not reported to the police, housing issues
- CP plans / deplanning
- Changes in GP/Health professionals
- Medical history including accidents/incidents requiring treatment
- Serious illness
- Hospital admissions
- Diagnosis of specific condition
- Episodes of being looked after
- Change in legal status
- Change of name
- Change in birth family household/relationships
- Change in birth family address
- Significant family events e.g. pregnancy, miscarriage, deaths
- Change in school/college
- School exclusions/incidents
- Absence from school
- Educational assessments including additional needs/support plans

- Educational performance & results
- Employment
- Police logs about family/household
- Criminal proceedings & offences
- Transition Plan
- Contact visits. (This should include those visits supervised by Social Workers, Family Support, Children's Centre and Contact Centre Workers etc). It is important to note that it is the responsibility of the social worker to ensure that all contact visits (including supervised contacts) are recorded in the chronology.
- Any missing from home or education episode.
- Date of SEAM referral and why.
- Date of SEAM and recommendations.

Suggested Chronology events for Children in Care:

- Date of birth of child
- Family history e.g. parents' childhood, their significant life events
- Start/end dates of SW involvement
- Changes of Social worker
- Strategy meetings and S47 investigations
- Assessments
- Child's words, views, feelings and behaviour
- Significant other incidents e.g. significant observation during home visits
- Concerns about specific behaviours in the family including sexual behaviour, substance misuse, domestic abuse not reported to the police, housing issues
- CP plans / deregistration
- Changes in GP/Health professionals
- Medical history including accidents/incidents requiring treatment
- Serious illness
- Hospital admissions
- Diagnosis of specific condition
- Being looked after
- Changes in placement
- Change in legal status
- Change of name
- Change in birth family household/relationships
- Change in birth family address
- Significant family events e.g. pregnancy, miscarriage, deaths, self harming
- Change in school/college
- School exclusions/incidents
- Absence from school
- Educational assessments including additional needs/support plans
- Educational performance & results
- Employment
- Police logs about family/household

- Criminal proceedings & offences
- Pathway Plan.
- Records of key Management decisions
- Contacts or referrals about the child and/or family.
- House moves
- Statutory visit form
- IRO Review recommendation/Review summary of either Pathway Review or C.L.A (it may be possible for these to be automatically populated)
- Incidents of missing from care, inclusive of details and actions
- Child returned from missing from care inclusive of a summary of details and action taken
- Child deceased.
- month summary in total
- PEP Note in the chronology the date completed and cro
- S.D.Q note the score and any action taken if required e.g. referral to ss reference with and cross reference with forms CAMHS
- Missing from care meeting(Cross date and brief summary of discussion and key actions)
- Date of referrals to SEAM and why
- Date of SEAM and recommendations
- Statutory visit form to be embedded in the chronology
- monthly summaries to be embedded in the chronology
- Dates P.P Regs were approved and summary of the context of the P.P report
- Any Legal Planning meeting includes brief summary of context and decisions
- Any legal proceedings. e.g. Date I.C.O made or date S.G.O made
- Records of Key management decisions
- Contacts visits. (This should include those visits supervised by Social Workers, Family Support, Children's Centre and Contact Centre Workers etc). It is important to note that it is the responsibility of the social worker to ensure that all contact visits (including supervised contacts) are recorded in the chronology.

Suggested Chronology events for SWET

- Dates of birth of significant parties i.e., parents, children & relevant others
- If there are any immigration issues, the dates when the parents arrived in the UK and their immigration status
- Dates of any relevant placement moves or date child/ren became 'Looked After'
- Dates of any relevant referrals to Children's Services
- Date and brief description of any injuries to the child/ren
- Dates the parties relationship began/ended
 - Dates of any other proceedings i.e., if any private law applications issued or previous care/supervision proceedings including dates of Care Orders etc.
 - Detail outcomes of proceedings.
 - Dates of any relevant police incidents and details
 - Dates of any prison sentences
 - Dates of any statutory assessments and outcome i.e., Child & Family Assessment

- Dates of any significant reports completed i.e., s7/37 reports, viability & parenting assessments
- Dates of Initial & Review Child protection Conferences and outcome
- Dates of any support service referrals i.e. CAMHS and outcome
 - Dates of statutory reviews
 - Dates of change of placements
 - Date of decision to commence PLO and the dates of the PLO letters
 - Dates of any Family Group Conference
 - Dates and brief details of any precipitating incidents
 - Date of decision to commence proceedings

Linking and embedding Chronologies into practice

- The allocated worker must ensure that there is an up to date chronology kept electronically on every new case started at the point of contact
- A chronology must be updated at key points in the process of a case when a decision has been made, when there is a change of status or a significant meeting or review.
- Family Support, Children's Centre, Contact Centre Workers and Outreach Workers must enter into the chronology any key issues arising from their work with service users.
- Managers and IROs must ensure that a chronology has been completed at critical points.
- The three monthly summaries or the up to date chronology should be seen and discussed in supervision on a regular basis and should be part of case file audits
- Managers, IROs and Senior Practitioners should have both a QA role and a supportive one in promoting good practice.

How to create a Chronology on Liquid Logic

Information that is electronically recorded in ICS for an individual will be **automatically listed** in the **History** tab.

n.b. There are five separate items that the practitioner would have to insert manually;

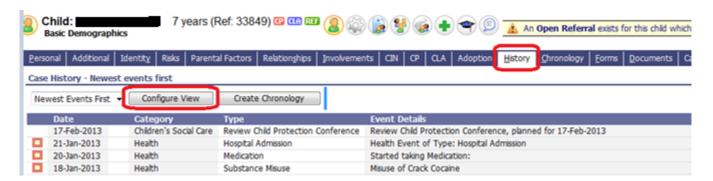
- Birth of Child
- Death of Child
- Child & Family Assessment Completed Date
- Change of GP/Health Professional
- Evidence of User Involvement eg when Child and Family Assessment was signed and distributed

Adding items manually shall be discussed towards the latter part of the document.

The default view for the History tab will show **all events** with the newest event at the top.

Important

The **CONFIGURE VIEW** button should only be used by the practitioner who initially creates the Chronology eg **MARAT**

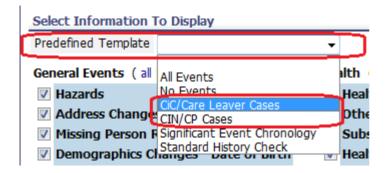


To assist with the **initial creation of the chronology**, templates have been created that shall include all of the items that are suggested in the Policy.

Example of when the Template would be used

Potentially, MARAT could just add items from the **HISTORY Tab** as and when they happen, however, if say the practitioner does not have the opportunity to create the Chronology until after the ICPC then the template feature could be used to capture all of the necessary intelligence.

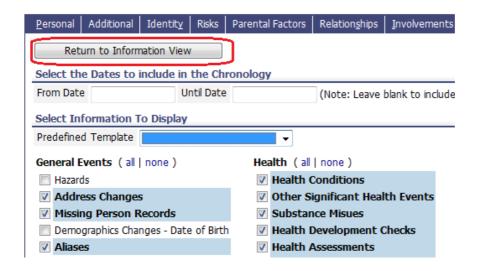
Once the CONFIGURE VIEW button is clicked the practitioner would ordinarily choose from one of the following options:



To impress the point, if you are in the Permanence Team and you have no record of a Chronology, it would be in your interest to:

- Click on the CONFIGURE VIEW button
- Choose CiC/Care Leaver from the Predefined Template Picklist

You would then click on the Return to Information View button:



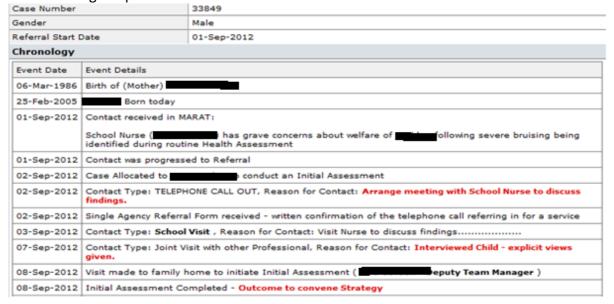
.....and then CREATE Chronology!!

Case History - Newest events first



All of the items from the HISTORY TAB shall now demonstrate in the Chronology.

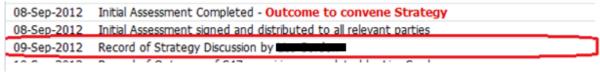
The following is a print version screenshot:



The policy recommends that the Chronology should "Not be an Assessment but should contain sufficient detail" – with this in mind, it may be necessary to add more information to certain events in the Chronology.

Example:

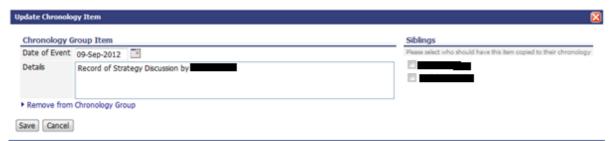
The Chronology shall demonstrate a Strategy Discussion having taken place but it shall not be accompanied by any supporting information



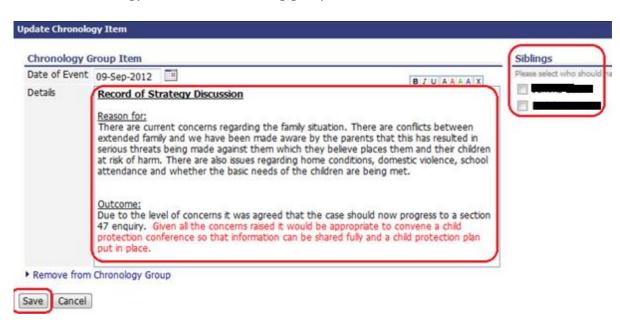
This is where the practitioner, **in the meantime**, shall use their discretion as to what text would make it more meaningful.

Alternatives at this point are:

Double-click on the row and this shall present the event



You can now add text directly into the box and SAVE. No You can even assign this entry into the Chronology of those in the sibling group!!!



Meaningful information added, you could then add to siblings and SAVE.

Once saved the new information sits directly in the Chronology!

	· ·g /
08-Sep-2012	Initial Assessment Completed - Outcome to convene Strategy
08-Sep-2012	Initial Assessment signed and distributed to all relevant parties
09-Sep-2012	Record of Strategy Discussion

Reason for

There are current concerns regarding the family situation. There are conflicts between extended family and we have been made aware by the parents that this has resulted in serious threats being made against them which they believe places them and their children at risk of harm. There are also issues regarding home conditions, domestic violence, school attendance and whether the basic needs of the children are being met.

Outcome:

Due to the level of concerns it was agreed that the case should now progress to a section 47 enquiry. Given all the concerns raised it would be appropriate to convene a child protection conference so that information can be shared fully and a child protection plan put in place.

If you are unsure what information should be added to the event, you can use the HISTORY TAB to interrogate the form/event in question and copy text from it to append to the Chronology.

Example

The Chronology shows ICPC Report completed by Lisa Gordon. If you wished to seamlessly enter the Report to perhaps use say, parts of the Analysis to inform the Chronology; this is what you would do.......



......click back onto the HISTORY TAB



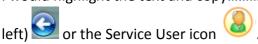
....find the report and click on it.

17-Sep-2012	Children's Social Care	Initial Child Protection Conference	Initial Child Protection Conference, held on
12-Sep-2012	Children's Social Care	Form Completion	Initial Child Protection Conference Report

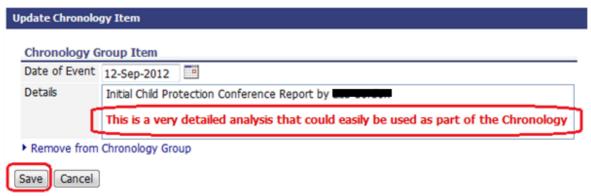
.....this shall open the form and you can copy the text you wish to be added to the Chronology!!!



I would highlight the text and copy......click on either the BACK ARROW (top



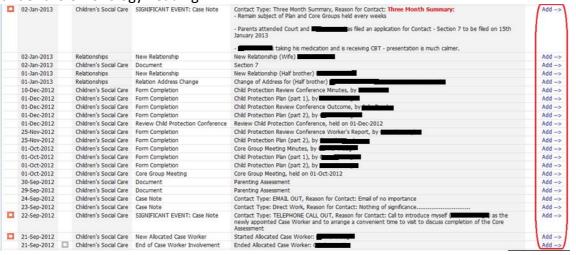
Go back to the Chronology TAB, double-click on the event and paste in your copied text!!!!!!



Adding items to the Chronology

Items can be added from the History Tab into the Chronology Tab, allowing the user to build a relevant chronological view.

On the History tab, each line of event information will have an **add** option on the right under the Chronology heading.



This "example" demonstrates a Case that has been transferred to the Family Team and all of the items that have happened in the system have found their way into the History.

The recommendations within the Policy shall determine which items you ADD to the Chronology. In turn, when you add the item you (the practitioner) shall choose whether to add accompanying text.

Adding items that are not generate from the HISTORY TAB

(e.g. 6 identified items at the start of this document are clear examples)

If you wished to demonstrate, say, change of Health Visitor you would have to add this in manually. To do this, you would go to the Chronology Tab and use the Add New Chronology Item link

	Multi-sange Bassansa with Dalies Interview and formal Medical
2-Sep-2012	Multi-agency Response with Police Interview and formal Medical Initial Child Protection Conference Report by
	This is a very detailed analysis that could easily be used as part of the Chronology
7-Sep-2012	Initial Child Protection Conference, held on 17-Sep-2012
	Made subject to CP Plan - Category of Actual Neglect/Likely Physical
7-Sep-2012	Outline CP Plan created and can be viewed within the final distributed minutes.
0-Sep-2012	Initial Child Protection Conference Minutes completed by Maintaine and distributed to all parties concerned
1-Sep-2012	Ended Allocated Case Worker: ************************************
1-Sep-2012	Started Allocated Case Worker:

If I wanted to add a change of Health Visitor on the 16th September 2012, I would click on the link, insert a date and some text and click on the CREATE button.



It would then demonstrate within the Chronology.



Printing a Chronology

From the Chronology tab, click **Print Current Chronology** to display a printable view.

	Made subject to CP Plan - Category of Actual Neglect/Likely Physical	
17-Sep-2012	Outline CP Plan created and can be viewed within the final distributed minutes.	
20-Sep-2012	Initial Child Protection Conference Minutes completed by Initial Child Protection distributed to all parties concerned	
21-Sep-2012	Ended Allocated Case Worker: (MARAT)	
21-Sep-2012	Started Allocated Case Worker:	
Add New Chronology Item		

Add New Chronology Item Print Current Chronology

Simply file and PRINT!

Quick Guides

Creating a Chronology On Liquid Logic

- 1. Open the child's Liquid Logic record.
- 2. Click on the History tab.
- 3. Click on the Pre-defined Template tab.
- 4. Click on Configure View and a table of tick boxes will appear.
- 5. Un-tick all the tick boxes that you do not want to appear in the Chronology. For most chronologies relating to permanence and transitions cases you will need to untick the following box's:
 - The contacts box
 - The case notes box
 - The Birth Family box
 - The Social Networks box
- 6. Please ensure that the **significant events box is always ticked.** Significant Events are created in the case notes .If you want a case to be included in your chronology then please ensure that you click the box that marks the case note as a significant event when creating a case note.
- 7. Once you have configured the tick boxes click the 'Return to Information View'
- 8. A draft history will then appear.
- 9. Click 'Create Chronology' and a box question box will appear. Press yes and a <u>basic</u> <u>chronology</u> will be produced.

How To Generate a Significant Event That Will be Included in Chronology

- 1. Check case notes.
- 2. Click 'Add Case Note'.
- Generate a case note in the usual way but for significant event case notes that you
 want to be included in Chronology you must ENSURE THAT YOU CLICK THE
 SIGNIFICANT EVENT BOX.
- 4. Once you have created the case note click 'create and close'.
- 5. Click the history tab. The significant event will appear in the History log.
- 6. Click the Add button relating to the significant event that you have created in the case notes and it will be placed in the chronology.

Key Data

It is the social workers responsibility to ensure that key data for child/young person and their family is kept up to date.

Historical Case Files

In those cases where a child has an historical paper case file that was created prior to electronic case files, this case file will be retrieved by MARAT and the file's location recorded in the Additional tab on ICS. Any physical movement of these files (for example between teams or on return to archive storage) should be recorded in the Additional tab.

Case Closure/Transfer

Before a case can be closed or transferred the following actions are required by the social worker/lead professional:

- 1. A case transfer summary sheet is completed electronically by the worker and electronically authorised by their manager.
- A social worker/lead professional must ensure that where appropriate, all relevant documentation (Early Help Assessment, Child and Family Assessment etc) has been distributed to the young person and their family/carers. A letter should be sent to the young person and their carers informing them of the decision to close/transfer the case file/case responsibility.
- 3. In cases involving a vulnerable child the social worker/lead professional has spoken with the child alone and recorded their views and wishes.
- 4. In cases involving a vulnerable child the social worker/lead professional has spoken with the carer and recorded their views and wishes.
- 5. In cases involving a vulnerable child the social worker/lead professional has agreed a plan for the ongoing promotion and safeguarding of the child's welfare.
- 6. In cases involving allegations of deliberate harm to a child the social worker/lead professional has spoken with the child alone and recorded their views and wishes.
- 7. In cases involving allegations of deliberate harm to a child the social worker/lead professional has spoken with the carer and recorded their views and wishes.
- 8. In cases involving allegations of deliberate harm to a child the social worker/lead professional has visited the accommodation in which the child is to live.
- 9. In cases involving allegations of deliberate harm to a child the social worker/lead professional has sought the views of all the professionals involved.
- 10. In cases involving a deliberate harm to a child the social worker/lead professional has agreed a plan for the ongoing promotion and safeguarding of the child's welfare.
- 11. A letter should be sent to all agencies involved to notify them of the decision to close/transfer the case

For further guidance on Case Closure/Transfer please see both the CYPS Protocol For Case Responsibility and Transfer of Cases in Children's Social Care, and the CYPS Records Management Procedures.

Review

This document will be reviewed annually, and in light of any changes to procedure in between these annual reviews, a new draft will be issued and approved as necessary.