Chronology and Case Summary Practice Guidance July 2015

CHRONOLOGY

"Chronologies have become one of the most talked about and least understood tools in modern social work practice" (Eileen Munro).

Definition of a Chronology

A chronology seeks to provide a clear account of all significant events in a child's life to date, drawing upon the knowledge and information held by agencies involved with the child and family.

Why a Chronology is Essential

Social work assessment has always been concerned to consider past events and their relevance to a person or family's current situation. There are limitations in any risk assessment but an accurate chronology can assist the process of assessment and review. The chronology is a tool which professionals in a range of disciplines can use to help them understand what is happening in the life of the child. Many enquiries into the care of children have concluded that a chronology could have helped towards an earlier identification of risk.

In the 2000 High Court Judgement, Re E and Others (Minors), Bracewell J issued guidelines to social workers which included the recommendation that the top document of every social work file should be a running chronology of significant events kept up to date so as to facilitate identification of serious and deep routed problems rather than the circumstances triggering the instant referral.

When is a Chronology Required?

All allocated cases need to have an up to date chronology. This is an indication of good practice. Persistent failure to achieve this standard will be addressed as a performance issue.

Chronologies must start on ICS from the day that you were allocated the case. It is expected that before this there is a case summary inputted onto ICS that details our journey with the child (i.e. summarising briefly what has happened with the child prior to the case being allocated to you). Every young person currently open to Children's Services must have an ICS chronology by the end of September. The case summary and the chronology must be updated as an absolute minimum every three months.

What should a Chronology consist of?

A chronology is not expected to be a repetition of the narrative contained in process or case recordings, but key events indicating incidents or issues within a family or which significantly affect a child's life. It therefore requires familiarity with the case information, and analysis to identify the critical moments in a child/family's life experience.

Core elements of a chronology include:

- Key dates of birth, life events and moves
- Consists of facts not opinion
- Transitions and life changes

- Key professional interventions
- A very brief note of an event e.g. a fall down stairs, coming to school with a bruise
- The actions which were taken as a result of the event, for example an assessment may have been undertaken but what was the outcome
- Consists of information from a number of sources including social care, health and education
- Constructed of sentences
- Succinct
- Accurate
- Relevant
- Have a sense of purpose

A chronology is ***NOT***:

- Just a reference to events or contacts
- A case narrative
- Copied across from ICS history. "*While ICT should be used where available this should be with caution and professional judgement and editing should be used to ensure that a meaningful document is produced" (Munro Feb 2011)*
- Repetition of case recording

Practitioners ***MUST*** use their professional judgement about how detailed a chronology should be and what events to include.

How can a Chronology support your Practice?

Chronologies are working tools, not an end in themselves and can support your work with children and families in a number of ways:

- Organising information
- Inform planning
- Provide an accurate picture of the young person's journey
- Highlights gaps that may need further assessment
- Early indication of emerging patterns or concerns
- Direct work with parent or carer to understand the impact of events on the family
- At the start of an assessment a chronology can help organise historical information gathered to assist in predicting future behaviours, areas of potential risk, risk heightening factors, protective factors and parental capacity for change
- Neglect by definition occurs over extended periods of time. The compilation of a timeline of events which may individually not give course for concern may lead to an earlier identification of possible abuse or neglect
- Life story work – this should not be completed without a clear understanding of a child's history – the effective use of a chronology will help to minimise the emergence of unexpected facts in the process of the work

No chronology is going to be useful if it is not read and analysed. Keeping a chronology up to date whilst working with a young person and their carers will provide valuable information when the case is reviewed.

Example of an ICS Chronology

Chronology

Chronology	Event Date	Event Details	Impact for Child/Person	Document Ref
31-Jul-2002	31-Jul-2002	Children's Services received a referral regarding a domestic violence incident between Mary and James. Mary presented at the police station to report that she had been assaulted by James. Mary had a black eye and bruise to her shin and foot. She had been kicked and punched by him. Mary is currently six months pregnant.	Initial assessment undertaken to determine any risks posed to the unborn child.	
02-Aug-2002	02-Aug-2002	Initial assessment completed. Concerns for unborn due to ongoing domestic incidents and James' alcohol misuse.	Case to progress to strategy discussion due to current risks to the unborn baby.	
07-Aug-2002	07-Aug-2002	Strategy discussion held. Health shared concerns in respect of Mary's mental health while the police identified two historic domestic incidents.	Concerns to the unborn baby are a result of alcohol misuse, domestic violence and mum's mental health. Section 47 enquiries are required.	
04-Oct-2002	04-Oct-2002	Child Protection Conference held.	Unborn baby was made subject to a Child Protection Plan under the category of Neglect.	
17-Nov-2002	17-Nov-2002	Birth of Myley Bethany Jackson.		
18-Nov-2002	18-Nov-2002	Contact received from West Cumberland Hospital. Mary gave birth to a baby girl at 6pm yesterday. Mother and baby remaining in hospital. Staff Nurse reported that initial observations between mum and baby are positive; mum is attentive to the baby's needs and has started breastfeeding. Request for allocated social worker to contact post natal ward to discuss plans for discharge.	Initial observations would indicate that mum is attuned to the baby's needs and a positive attachment is developing. Following social worker visit to hospital, agreed mother and baby could be discharged home.	
24-Jan-2003	24-Jan-2003	Review Child Protection Conference held.	Given the progress made in respect of Mary accessing and utilising Mental Health services and no further domestic incidents, unanimous decision made for Myley to no longer be subject of a Child Protection plan.	
05-Feb-2003	05-Feb-2003	Child in Need meeting held. Health Visitor and Community Mental Health worker continue to acknowledge Mary's progress in meeting her own and Myley's needs. Myley is meeting her developmental milestones and observed evidence by Social Worker of good attachment. James has had no contact over this period.	Myley's needs are being met by Mary. Further Child in Need meeting to be held to consider future support plan and who will provide the support.	
26-Mar-2003	26-Mar-2003	Child in Need meeting held. Myley continues to meet her milestones while Mary is accessing her appointments with the Community Mental Health worker on a two weekly basis. James has still had no contact and is not requesting contact.	Myley continues to thrive under mum's care. Threshold for Child in Need no longer met. Case to be closed to Children's Services. Health Visitor to be lead professional in respect of a Team Around the Child with Mary's consent.	

CASE SUMMARY

What should a Case Summary consist of?

As with chronologies, all ICS case files should include a case summary. The case summary should provide the reader with an outline of the history of involvement with Children's Social Care, the reasons why Social Care are currently involved and the purpose of that involvement. It should also include any crucial information and/or key safety features to be noted by the reader - examples of these might include people within the friends/family network who should not be having any contact with the child due to the risks they pose, or specific reference to the young person's CSE safety plan (and where this document can be located) or issues with regard to payments from Children's Services etc.

Case summaries must be updated as an absolute minimum every three months. Additionally, the case summary should be updated upon transfer to another social worker or team. The updated case summary should not just be the adding of an extra paragraph, as, over a period of time, this would obviously make the case summary too lengthy and cumbersome. Instead, it should be an updated version of the child's circumstances. However, some content would obviously need to be remain in every case summary, such as the reasons why the child became Looked After, when and why the child became subject to a Child Protection Plan.

The summary can help to ensure continuity and is an important source of information for colleagues and supervisors in the absence of the case holder.

The case summary should be directly related to the aims and objectives set out in the child's plan and can be a useful tool in setting out the tasks necessary to achieve the objectives. Completing or sharing a case summary with a family offers an opportunity to reflect on progress over the period covered by the summary and discuss both achievements and difficulties. It should also assist the practitioner with an opportunity to reflect on the effectiveness of interventions and review progress towards agreed goals.

Case Summary Examples

Example 1

History:

Crystal became subject to a Child Protection Plan on 06/07/12 under the category of neglect due to her mother misusing alcohol and illicit substances. Two months later, Crystal was left in the care of her mother's partner, Troy Blacklock, whilst she went out drinking and she was sexually assaulted by him. This resulted in her becoming Looked After (on 10/09/12). On 12/06/2013 Full Care Order and Placement Order were granted.

Crystal subsequently alleged that she and Luke had been sexually abused by their mother and all contact was terminated. In August 2013 Crystal and Luke met for contact - this was not positive for Crystal and advice given from NSPCC was that continued contact would re-traumatise her every time she met Luke. The plan is for letter box contact between the siblings; this is yet to be finalised (17/08/2015).

An adoptive placement was not identified for Crystal - her Foster Carers had given a verbal commitment to long term fostering (after NSPCC work completed) but then changed their minds,

when Crystal tried to strangle the family dog. Crystal had two further placements before being coming into her current placement with Alice Jones. There have been no known further incidents of harmful behaviour towards animals.

Current placement and needs:

Crystal is now placed in Old Street, New Town, with a private agency carer, Alice Jones. This is being assessed as a short to medium term placement but may become a permanent placement if Crystal continues to show the progress she has been making in her placement. The placement provides good routines, emotional warmth and stability and carers demonstrate a good understanding of the immediate and long term risks that could impact on Crystal because of the trauma that she has experienced.

Crystal continues to have occasional outbursts within placement, whereby she becomes verbally and physically aggressive. Carers find this difficult at times, made worse by the break in therapy by CAHMS: **Contingency Plan**: until therapist resumes her work, support will be provided by allocated SW, Fostering SW and Barnardos.

School: Crystal is attending St Katherine's Primary School, New Town. The PEP is due to be reviewed in September 2015: Crystal is doing well academically at school but there are issues with her making and keeping friendships (her behaviours often alienate her from her peer group).

Interests: Crystal attends dancing, swimming and would like to go to Brownies. She reads and loves creative play. Crystal also likes making cards and things with stickers, and she likes to bake.

Crystal has been assessed by CAHMS in New Town: to explore and support Crystal to process trauma and develop positive coping behaviours (linked to her acute anxiety in previous placement) and the concerns - when in the care of her mother sexual behaviour was used as a means to soothe Crystal.

Contact: Crystal does not have any contact with any family members or her parents. There is still a Placement Order in place but we need to think about ending this as adoption is unlikely for Crystal.

Key points:

*** Crystal needs Permanence.**
*** Crystal wants to know if she can have letterbox contact with her younger brother, Luke.**
*** Crystal is working through her Life Story book with her carer Eve: Crystal would like more information about her birth father.**
*** Crystal is confused and wants to know who is who in her family.**
*** Crystal can disassociate from subjects that she finds difficult to talk about.**
***Crystal needs still needs a passport.**

Dates:

CLA REVIEW: 19/11/2015
PEP: 11:00 a.m. on 16/10/2015
Visiting Schedule: (6 weekly): 18/9/15, 18/10/15, 24/11/15, week beginning the 28/1215.

Example 2

Background information

Children's Services have been involved with CJ since his birth in 2007. Concerns were originally raised when the health visitor became aware that George Saunders was CJ's father. George has an extensive history in respect of his alcohol misuse and this was a feature of the concerns that led to removal of two of his other children. During the course of the care proceedings George was assessed by Dr T N Stewart, Consultant Forensic and Clinical Psychologist. In February 2008, Dr Stewart compiled a report which stated that in his opinion that the likely prognosis for George's alcohol misuse was, in both the short term and in the long term, poor. The evidence would suggest that George has not been able to abstain from abusing alcohol for a significant period of time.

It is clear from the case records that both parents have experienced an unsettled upbringing. George witnessed a lot of domestic abuse and Victoria witnessed parental fights and arguments. Victoria was placed with her father due to concerns that her mother was not prioritising the needs of her and her sibling and there were concerns about her safety. Both parents have a history of misusing alcohol and drugs and the records in respect of George indicate that he presents as volatile.

The concerns that were raised led to CJ being placed on a Child Protection Plan under the category of neglect in early 2008. The concerns have centred on domestic violence between the parents, alcohol and substance misuse. On this occasion, CJ's mother, Victoria Grainger was able to demonstrate that she is able to make the necessary changes to safeguard CJ however within 6 months of CJ's name being removed from the Child Protection Plan in September 2008, it was evident that she was not been able to maintain these changes for any significant amount of time resulting in CJ being placed on the Child Protection register for the second time in May 2009.

During the previous Child Protection plan, extensive work has been undertaken with Victoria in respect of her lifestyle, the impact of domestic violence and the risks in respect of George were shared with Victoria. During this process Victoria appeared to understand and accept the concerns but nevertheless returned to her relationship with George and began misusing drugs and alcohol again.

Care Proceedings

Due to the concerns persisting for CJ, the Local Authority initiated Care Proceedings in March 2010. An Interim Care Order was granted at that time. The Final Hearing took place on the 4th September 2010. Paternal grandparents' application to the Court to be made party to the proceedings was refused.

The Court granted a Full Care Order and Placement Order in respect of CJ. The Court agreed that an adoptive placement should be sought, if all enquiries are exhausted in relation to this, CJ would remain in long term fostering.

Current Placement

CJ is placed with a private agency carer, Mary Smith. This is being assessed as a short to medium term placement while the family finding process is ongoing but may become a permanent placement if this is not successful. The placement provides good routines, emotional warmth and stability and Mary demonstrate a good understanding of the immediate and long term risks that could impact on CJ because of the trauma that he has experienced. CJ has made some progress in respect of his behaviour since being placed with Mary, but there continues to be signs of distress and aggression, particularly following social worker visits

Contact

Contact has been set at 6 times a year with mother until adopters are identified where mum will be offered a farewell visit. The children's father has no ongoing contact but is to be offered a farewell contact.

Key points

CJ needs Permanence.
CJ needs a Life Story book.
CJ needs a passport.
CJ needs direct work around separation and loss.

CJ

CJ loves to play football and supports Carlisle United. He additionally loves his X box, however, can be challenging when asked to switch it off after being on a substantial length of time. Mary and school are trying to encourage him to read. CJ is considering joining the local cub scouts which would assist with his socialisation.