Buckinghamshire BSCB Safeguarding Children Board

BSCB Audit Summary Findings

Children with Disabilities

July 2018

What did we do & why?

In 2018, the Performance and Quality Assurance Sub Group were asked to undertake a re-audit on Children with Disabilities; the original Children with Disabilities audit was undertaken in 2009 and focused on children who had been the subject of a Section 47 enquiry (2007– 2008)

The re-audit was seeking to evidence the local perception that the application of thresholds has improved across the partnership, and to test professional knowledge in relation to this specific group of children, where there are often additional challenges in applying those thresholds.

Methodology

Ahead of the audit session, Children's Social Care (Bucks County Council) was asked to provide a sample of four children known to both their service and Early Help

Successes

The audit identified a number of successes or areas of good practice within services. These were:

⇒ There was appropriate use of interpreters, by both Health Visitors and Children's Social Care

⇒ In one case, there was a high level of positive and effective communication between services involved with the child and family (Health Visitor / Social Worker / Speech & Language Therapy / school / nursery and Health services). This communication was also recorded efficiently.

⇒ Accident & Emergency thresholds for the use of the self-harm pathway were followed appropriately.

⇒ There was "a lot of collaboration" noted for one case between Care Programme Approach (CPA) meetings at Care Programme Approach (CPA) discharge, as well as Head of Service discussion between the Children Social Care (CSC) and Special Educational Needs (SEN) Teams

⇒ In the event of a crisis situation, Mental Health services responded well.

⇒ In one case, the school was noted as trying a range of in-house solutions to support the child in response to bullying.

⇒ SEN services have provided training to SENCOs in relation to the SEN gap.

⇒ In two cases, there is evidence that some professionals have attempted to capture the Voice of the Child.

⇒ The recent update of Health Visitor Guidance to state that after two missed appointments, the Health Visitor should go back to the original referrer.

In one case, Children with Disabilities Team described good multi agency working with effective communication as well as easy to set up, well attended meetings.

The voices of both the child and their mother had been captured and the SEN team provided evidence on co-ordinated social care appointments and annual review meetings, which reduced the need for multiple appointments.

There is also evidence of a positive response from Police, with officers described as being "very patient with the child".

CAMHs records also show evidence of good multi-agency working; the positive communication and the combined working of services to meet the needs of the family has resulted in the mothers' increased trust in agencies.

Key Learning from Audit

The Bigger Picture

There is evidence that professionals have a tendency to support the child and family by managing a presenting need, rather than focussing on the bigger picture.

This can be due to the fact that families often present when at crisis point, however professionals need to ensure that all relevant background information is considered so that all decisions are fully informed.

Voice of the Child:
In only one case is the Voice of the Child clearly heard.
In the other three, this element is either minimal - for one, the SEN assessment captured the Voice Of the Child and detailed what the child wanted to happen in terms of care and support - or missing entirely.
One agency return stated that the voice of the child could not be captured due to “age and disability”.
This suggests a gap in understanding as to what is meant by Voice of a Child.

Professional Curiosity:
For Child 3, the audit session were made aware of significant background information which practitioners involved with the family were not previously aware of.

It was noted that the mother was viewed by professionals as “challenging”, however there is no evidence that professionals had considered what that would mean for the child, whose daily involvement with this parent is their lived experience, nor had there been any recognition of risk to the child outside of their disability despite safeguarding concerns raised by mother that she could not cope.

Late diagnosis:
For Child 2, a late diagnosis of ASD meant that the child had struggled for a long time in mainstream school. Given the child's low cognitive ability, the audit panel considered how it had felt for **them** to be in an education setting which was not suitable for their needs and whether the educational focus meant that the school had not pick up on safeguarding issues.

It was noted that once the child moved into two specialist establishments as an early teen, a clear plan was put into place with regards to their education and progress, and their voice was captured both within their own disclosures and as part of the establishments risk assessment.

Early Help:
As well as a late diagnosis, there is also evidence for Child 1 that Early Help opportunities were missed. A statutory assessment was undertaken for the family, with the decision reached that involvement from Family Resilience was the most appropriate support.

The audit panel queried whether it was appropriate for a family to have a CSC record created in order to be able to assess Early Help Services; is there is a knowledge gap as to how to assess Early Help Services and can this cause delays in providing services to children and their families?

Missed appointments:
Again, the impact on the child was not always considered during missed appointments. Whilst an agency may not consider two missed appointments to be of significant concern, this may represent a long period of time in the life of the child. <u>Professionals must consider the lived experience of a child.</u>

The key focus in the majority of these cases appears to be on the wants and needs of the parent or carer, and the ways in which they can successfully manage their child’s disability.

There appears to be little evidence as to any aspirations for these children, with services focusing on the demands of their “problems” rather than looking at ways for them to improve or achieve.

Due to the added complexities and challenges of these cases, there is also a clear need for further consideration into a separate thresholds document for children with disabilities.

Key Learning from Audit

Information Sharing

The failure to share information was not only an issue for Child 3. Significant medical information about Child 2 was not known by a number of agencies. As this information may well have impacted on the child's self-perception and their view of their sibling, as well as being a possible source of the bullying they experienced, it was agreed that all relevant agencies should have been privy to this information.
There are also issues around the lack of records for this child in general, with decisions and assessments only available for the last few years; the view of the audit session was that there was a general "assumption" by professionals that the child's mother and school were "keeping things going".

For Child 1, there were queries around how the multi-agency partnership working had progressed, with a need to clarify the sharing of information between statutory and specialist agencies. It was noted that often specialist agencies only have access to information directly relating to the focus of their services, which can result in missed opportunities in terms of support, signposting and escalation.

Father Involvement

The audit panel noted the continued issue with regards to "missing men"; that the **impact**, **role** and **feelings** of the child's father, or other significant male carers in the children's lives, were not visible.

For Child 1, Children's Social Care noted that the child's father was 'silent' as far as their records reflect.

For Child 2, both the SEN assessment and school records only reflect the mother's details, so in an emergency the child's father could not be contacted, and the SEN case officer acknowledged that they had never met nor spoken to the child's father. The audit panel noted that whilst opportunities had been missed in failing to capture the views of the father, or considering his impact on the home, records indicate that the father had contributed to the CAMHS assessment work.

In contrast, for Child 3, the mother's partner is listed as "Dad" despite not being a biological parent. There is no clear recording as to the current situation within the household, and the child's view regarding this title of "Dad" is unknown.

One of the recommendations from the 2009 Children with Disabilities Audit highlighted the need to consider fathers within assessments.

"The systematic assessment of fathers and male carers when they are having or could have access to the child: *There has been reliance on what the mother of the child has to say about a father who is no longer in the family household. Social Care and Conference Chairs should challenge any statements and look for further information to support / contradict what is being said."*

Recommendations

⇒ Agencies to take a **multi-agency perspective** on children "not brought" to appointments….

Whether that is after contact has been established **or** where there has been no engagement.

⇒ Assessments should capture the **lived experience of the child**

Not **just** the impact of the disability.

⇒ Understanding of risk to be regularly reviewed and to include **broader** safeguarding factors…….

Not **solely** focused on the disability.

Recommendations

⇒ **All** adults who are significant in a child's life should be visible in assessments…...

Including, **but not limited too:** biological fathers, step fathers and any other adult living in the household.

⇒ Children should receive appropriate services as early as possible when need is emerging.

⇒ Consideration should be given to services for children who may not meet the age criteria for diagnosis

For example: Pre - CAMHS

⇒ Early Help Services need to have more effective information and co-ordination so that families **do not have a Social Care record unnecessarily**.

⇒ Assessments should capture an understanding of the impact of **environmental risk factors** on the child

i.e. the focus was on the disability of the child, not on the safeguarding picture **as a whole.**

⇒ **Assessments should paint a clear picture of the aspirations for Children with Disabilities**

Next Steps & Further Information

The recommendations for the Children with Disabilities Audit have been developed into an action plan, which will be monitored via the Performance and Quality Assurance sub group of the BSCB.

The P&QA sub group will ensure that all recommendations are answered and evidenced by the relevant agency or service and will seek assurance that outcomes for children have improved.

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