BROMLEY SAFEGUARDING CHILDREN BOARD

MULTI AGENCY AUDIT 2017

An audit of 10 cases which did not meet threshold for children's social care intervention

AISLING CLARE

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1. Introduction

1.1 Bromley Safeguarding Children Board (BSCB) undertakes a rolling programme of audits and this report provides an overview of the audit undertaken in December 2016 which focused on multi agency service provision to children and young people who may be experiencing neglect. This piece of work was carried out by an external auditor on behalf of the Quality Assurance and Performance Monitoring (QAPM) sub–group of BSCB. The audit provides an evidence-based assessment on the strengths and areas for development of the partnership working with children and families who experience neglect. The remit of the audit explored the service provision experience of 10 children and young people who were referred to the MASH team for neglect and did not meet the threshold for assessment. The overview report will be available to the (QAPM) sub–group of BSCB who will be responsible for developing and implementing a multi-agency action plan informed by the findings and recommendation.

2. Audit sample

2.1 A random sample of 10 cases were selected by the Auditor of children and young people aged up to 16 years. Attention was paid in choosing the sample group to a selection of gender, age, ethnicity and multi-agency involvement. The sample group included 2 children with disabilities. The criteria for selection was that there had been a referral to MASH which had not met the threshold for Children Social Care (CSC) assessment. Some of the sample group went on to have further referrals during the timeframe and subsequently received further services within CSC. Some of the sample group had existing support through Common Assessment Framework (CAF). Many of the children and young people and their families were in receipt of universal services and had no additional support services.

3. Methodology

3.1 An independent auditor was commissioned by BSCB to lead the audit on behalf of the BSCB.

3.2 A meeting was held with the auditors and agency leads to input into the design of the audit tool and facilitate the multi agency process . Once the cases were selected partner agencies were asked to check their records to see whether the index child, their siblings or parents/carers were known to their agency. The records of the various agencies involved with the child or family were examined by a range of auditors identified by each of the agencies. Auditors were asked to review records over the 12 month audit period (November 2015 to November 2016) informed by the history each agency had with the child and their family. The next stage was each agency auditor completing a structured questionnaire which was then analyzed to provide aggregated data and contextual supporting evidence. The intention was that each audit would be graded in line with OFSTED's current framework. Gradings were not completed by agency lead auditors on all audits. The reason for this appeared to be lack of clarity about the auditor's task or in cases where there was limited information on the agency's records auditors felt that they were unable to make a reasonable judgment. There was also concern from some agencies around exposing areas of difficulty and further development within their service provision.

The gradings provided by agencies have been included in this report. These gradings have not been externally moderated due to the specialist areas of work provided by each agency.

3.3 The questionnaire focused on six key areas of activity:

1/ Recognition and Response

2/ Voice of the Child

3/ Case Recording/ Record Keeping

4/ Assessment, Analysis, Planning

5/ Supervision and Management

6/ Intervention and Review

3.4 Direct contact was made with the majority of service users and 2 children and young people to invite service users to provide feedback by meeting with the Auditor together with a QAPM Board member. This was unsuccessful – one service user agreed

to meet however cancelled on the day of the meeting.

3.5 A number of agencies did not have contact with the sample group during the timeframe so did not complete audits: Bromley Early Years, Women's Aid, Bromley Changes, Adult Social Care. London Community Rehabilitation Company (CRC) had provided a service to one service use however were unable to complete the audit due to service constraints.

3.6 MASH Practitioner's perspectives were invited through reflective feedback forms. Three completed forms were received. Some practitioners felt that their limited input into the cases did not provide enough material for reflection. Many of the sample cases had work from several practitioners (continuity of case working in MASH is difficult due to the throughput and timelines of MASH work).

3.7 The audited data was received and considered and the Auditor facilitated a multi - agency meeting for agencies to share their feedback on findings within their agencies and how the data resonated or otherwise between agencies. The Neglect Audit Learning and Feedback Forum was well attended by a diverse group of professionals across agencies. (Police were not represented and Education were under represented.) It was an effective forum enabling a landscape of neglect related services across agencies to emerge in terms of the quality of practice and process within agencies and the impact on children and families : useful and candid debate was generated around agencies' areas of further development and aspects of good practice. There was also discussion and concern raised across agencies in relation to external operating factors associated with the economic climate and further cuts to resources and constraints and how building resilience within the multi-agency networks will be an increasingly important to improving the quality of service provision.

4. Limitations

4.1 Many of the questionnaires were completed in detail with a well evidenced context demonstrating rigour in their grading, a smaller number were completed less thoroughly or were incomplete. Some audits had a central focus on procedural compliance with

less evidence around the quality and the impact of the work. Some of the auditors had not been briefed by their agency lead and were unaware of the audit taking place until almost the last minute thereby making the audit more a task to be completed rather than a reflective exercise as was intended. Some agencies found parts of the questionnaire less relevant to their services and because of this may have felt less connected to the single agency benefits of completing the questionnaire.

4.2 The electronic systems used by agencies were sometimes difficult for auditors to interrogate as the systems do not speak to each other. For example, Guardian is used by the MASH team and CareFirst (CF) is used by all social care staff. The two systems are not interlinked. Some of the children audited had long and complex histories but the Guardian database did not facilitate an effective appraisal of all the previous referrals as older referrals had not migrated to Guardian. CareFirst practitioners recorded their cases in various ways so it was not always easy to locate documents.

Synopsis of agencies performance and involvement

5. Health Visitors and School Nurses

10 audit submissions were received as this service had completed an audit for all of the sample group, some of whom had not received a service within the timeframe of the audit. Overall grading for submissions within the audit timeframe were Good for 2 cases, Requires Improvement for 2 cases and no grading for 2 cases were there was insufficient information to grade.

5.1. Recognition and Response Cases were graded between Requires Improvement and Good. Risk was generally appropriately identified however a lack of knowledge around neglect was apparent on occasion eg a focus on the state of the house did not make explicit connections between parenting capacity and the impact that the home and chaotic lifestyle would have on the children's emotional and behavioural development.

5.1.2 A lack of information sharing between schools and School Nursing service effected the quality of service to vulnerable children and young people.

5.2 Voice of the Child Good was assessed where there was clear evidence of the child's developmental progress and interactions with parent(s). The views of the child were well captured in " All about me booklet" by School Nurses.

5.3 Case Recording Requires Improvement where the transfer of knowledge from Heath Visiting service to School Nurse services had resulted in a loss of flow and progress with the family.

5.4 Assessment, Analysis and Planning The majority of cases were graded as Requires Improvement with one case graded as Good. There was sometimes a lack of challenge towards parents and optimistic views of parenting capacity which obscured the needs of the children.

5.5 Supervision and Management The majority of cases were graded as Requires Improvement with one case graded as Good. Discussion at supervision did not always take place on families with vulnerabilities so there were missed opportunities around consideration of CAF to support families. Procedures require all CP cases to be discussed in supervision which had not always happened. Decisions could also have been clearer in some instances.

5.6 Intervention and Review The majority of cases were graded as Requires Improvement with one case graded as Good. CAF were generally effective in supporting parents however some CAF's appeared to be drifting around timescales for Team Around the Child (TAC) meetings and actions: in these instances re-referrals to MASH could have been completed sooner. In other cases CAF meetings may have been stepped down too soon after Child Protection (CP) Plans or Child in Need (CHIN) Plans as change had not been sustained for long enough periods especially in the context of extensive histories of neglect.

6. <u>General Practitioners (GPs)</u>

6.1 The analysis is based on 7 audits submitted by the Named GP for Safeguarding which reflected their involvement. GP audits were graded Good overall for 1 audit and Requires Improvement on 2 audits. No grading was given on 4 audits.
One audit was incomplete.

6.2.1 Recognition and Response Good: There was effective communication with Health Visiting Service on one case when health issues were affecting parenting capacity which resulted in a safety netting plan including an enhanced service from Health Visitors.

6.2.2 Requires Improvement: GPs were working in isolation from other agencies - there had been no communication from Health Visiting or other agencies on the majority of cases, There had been no contact from MASH requesting or sharing information around concerns despite health related concerns such as mental health and substance misuse.

6.2.3 Professional curiosity was not always apparent as on occasion there was a reliance on neglect already having been identified by other agencies (it is acknowledged that GP's surgery direct contact with children and parents in surgery appointments is very limited).

6.2.4 Deficits in transfers of information within the health economy was also a theme. Children and young people with significant health issues had no outcome letters for hospital referrals for different health concerns on 2 cases. Health information had also not reached the GP from an A and E service to a young person who was assaulted and injured by a family member. The young person subsequently presented at the GP with anxiety related issues whereby the GP provided a service without awareness of such a significant incident.

6.3.1 Voice of the Child was graded as Good with the use of an interpreter where needed.

6.3.2 The ethnicity of the child was not recorded or unknown on 2 case audits.

6.4. Case Recording was described as being of a reasonable standard.

6.4.1 Coding of vulnerabilities was not always completed eg of vulnerable children for each child in a sibling group, on the parent's record to flag up vulnerable children, past history of DNA's and contact from MASH. Coding would assist GP's in their awareness of vulnerabilities within families.

6.5 Assessment, Analysis, Planning Good evidence of timely planning was reported around referring to appropriate services however referrals needed to include key information such as that the adult was a parent.

6.5.1 Analysis around parenting capacity was missing or very limited on some cases including one family where the mother was perceived as not coping well during pregnancy.

6.6 Supervision and Management No gradings were determined. Practice safeguarding Health Visitor/GP liaison meetings are held where safeguarding concerns are discussed when identified.

6.7 Intervention and Review Good was evident where a supportive relationship with the family was established with a significant amount of complex health concerns and vulnerabilities with the children.

6.7.1 Discussions around substance misuse did not always demonstrate that the history of alcoholism was factored in or critical analysis of a parent's ability to manage their alcohol relapse. One case evidenced a parent presenting with alcohol concerns at

partner agencies when the GP's record describes that this parent no longer had any alcohol problems based on the parent self reporting in a transparent manner.

7. CAMHS

7.1 One audit submission was received which reflected their involvement. The overall assessment was Good. The scope of the audit was limited with only one meeting with the family having taken place.

7.1.1 Recognition and Response Good: Thorough referral was made by Community Paediatrician. CAMHS contacted CSC as part of the referral process however CAMHS did not receive a copy of the Initial Child Protection minutes which would have assisted the assessment.

7.2 Voice of the Child Good: The child was helped to express themselves by drawing a picture as part of the assessment. The child's background and family history were recorded.

7.3 Case Recording Requires improvement: Safeguarding details needed to be recorded in the Safeguarding section as well as the body of the assessment.

7.4 Assessment, Analysis, Planning Good: Family are on a waiting list for parent/child psychotherapy . Seven month elapsed between referral and assessment including a short delay around parent(s) changing appointments.

7.5 Supervision and Management Good: The case was discussed at the Multi Disciplinary Meeting, the discussion was recorded and the outcome discussed with the parent.

8. The Princess Royal University Hospital, Kings College NHS Trust

8.1 Two audits were received which reflected their involvement. Overall grading was Good for 1 audit and no grading was determined for the second due to the very limited documentation.

8.1.1 Recognition and Response Good: Further support was considered and discussed with duty Social Worker in terms of a CAF.

8.2 Voice of the Child Voice Good: The young person was able to disclose domestic abuse and the young person's consent was obtained to involving the police.

8.3 Case Recording Good was evidenced with clear recordings of medical issues including dates, times and plans for investigation and assessment of these documented contemporaneously.

8.4 Assessment, Analysis, Planning Good: Documented plan for medical discharge with GP follow up. Documentation included police involvement, CAD numbers and Social care follow up.

8.5 Supervision and Management Requires Improvement as no management oversight was evident.

8.6 Intervention and Review Good: Child safety was prioritised by the young person being discharged into the care of the parent(s).

9 Bromley Drugs and Alcohol Service (BDAS)

9.1 One detailed audit submission was received which reflected their involvement. The overall assessment was Requires Improvement.

9.1.1 Recognition and Response Requires Improvement: BDAS were not made part of the Core Group for the CP Plan and received no information from external agencies despite the extensive partnership working with the family. This impeded their assessment process and was a missed opportunity around the parent accessing specialist treatment at an earlier stage.

9.2 Voice of the Child Requires Improvement: A home visit was conducted however the child was at school. The child's bedroom was seen and adequate toys and safe areas to play were observed.

9.3 Case Recording Requires Improvement: Recording was not always up-to-date. There was detailed evidence in chronological order of events, disability and mental health recorded.

9.4 Assessment, Analysis, Planning Good: Treatment Outcome Form (TOPS) a self report tool for those in structured treatment facilitated the service user and staff in measuring progress and sustainment of reduction of substance misuse. Levels of substance usage were gauged on a daily basis together with the service user's psychological and physical state and their overall quality of life. An 'Outcome Star' tool was used to measure service users' ability to change.

9.5 The Care Coordination Reviews provided an effective quality assurance process whereby changes in circumstances were identified and risks were managed adequately.

9.6 Supervision and Management Good: Supervision occurred monthly. Actions were reviewed and discussed in clinical meetings.

9.7 Intervention and Review Requires Improvement: It was not always evident that staff maintained a healthy scepticism when listening to the service user, accepting their

accounts without challenging them can lead to missed opportunities around service users becoming more insightful in their recovery.

9.7.1 Challenge was evident such as in response to the parent reporting that they slapped their child.

10. Education

10.1 The analysis is based on 6 audits submitted directly from schools one of which was incomplete. Audits were not received from all schools. The overall gradings were Outstanding for 1 case Good for 3 cases and Inadequate for 2 cases.

10.1.1 Recognition and Response Outstanding: Staff monitored a child's well-being and behaviour closely (due to the child's disabilities and extensive history of CSC involvement) and spoke to relevant agencies (CAF/MASH) when concerned. Safeguarding procedures were invoked at the correct time including clear dated incidents recorded and parent(s) being informed of referrals to MASH.

10.2 Good was evident where schools had effectively utilised their own systems and strategies in response to identifying neglect related concerns such as low attendance, hygiene and food related issues. Children were supported and monitored and the concerns followed up with relevant agencies such as CAF, MASH and the Traveller Support Workers. Partnership working within the Education system between Education Welfare Officer (EWO) , Admissions, School Family Worker and Headteacher had provided excellent support. There was evidence of considerable efforts made to engage and discuss the issues pro-actively with parents. Support and challenge was used effectively with staff being clear about expectations eg challenge around concerns about a child not receiving lunch. Positive reinforcement strategies were used with junior school children around low attendance resulting in an improvement in attendance and academic progress for one child .

10.3 Another school made extensive efforts around practical support including identifying community resources for the family, flexibility around the times the child attended nursery to accommodate the parent attending appointments, ordering Xmas Hampers from Foodbank and assistance around completing forms.

10.4 Special Educational Needs support has also been provided for a child's academic ability and learning behaviour where the parent(s) had participated in the meetings with the school SENCO.

10.5 Requires Improvement was described around deficits in communication with MASH: school shared concerns however there was no feedback, guidance or discussion and this would have helped to determine future strategy around any recurrence of concerns .

10.6 A lack of planning in relation to a child moving to an alternative family placement during a Section 47 investigation resulted in additional stress for a child and for the family members. School were not kept updated as to who would collect the child; there were further difficulties resulting from CSC asking the school to supervise contact between the child and the parent in school which was a very difficult situation.

10.7 Voice of the Child Outstanding was evident for a child in a Specialist Provision who had severe and complex needs. Staff developed methods to enable the child to speak. Signs (Makaton), symbols and pictures were used to support the child expressing their thoughts. The child drew pictures to try and show what was happening at home.

10.7.1 Good was evidenced in disclosures of abuse being written up in a concerns log detailing what the child said word for word.

10.7.2 There was evidence of high quality communication with a child with disabilities during a Section 47 joint investigation. The interview was informed by skilled communication strategies that the school had developed which took into account the

child's emotional well being, cognition and information processing skills. The School Safeguarding Team supported the child in the interview and observed skilful communication by the Social Worker and CAIT officer in making the child feel comfortable, making the purpose of the interview very clear and age appropriate discussion.

10.7.3 One case demonstrated effective planning for the child around support by designated staff members– the child was aware of which staff members were accessible at which times.

10.7.4 Requires Improvement has been assessed when there is little mention of the particular child within the sibling group.

10.5 Case Recording Outstanding**:** Staff completed detailed reports in a timely manner. Safeguarding records were kept in a secure location with an effective chronology of events recorded.

10.5.1 Good recording was evident in recording which captured detailed events, meetings and conversations with a parent.

10.6 Assessment, Analysis, Planning Good was evidenced in effective working relationships with family members whereby concerns have been discussed and acted upon at an early stage.

10.6.1 Good relationships with Social Workers has contributed to effective meetings and work progressing positively around the goals.

10.6.2 CAF meetings had effectively achieved goals across schools for a sibling group. All the professionals liaised regularly through email and telephone conversations. The parent had difficult relationships with particular professionals within the CAF however the professional group continued to work together effectively and was transparent with the parent about this.

10.7 Supervision and Management Good was assessed in terms of the Safeguarding team or Inclusion Team meeting regularly and discussing cases.

10.7.2 There was some evidence of challenge within the multi agency network: '*We are happy and confident to challenge agencies if we feel that we need to'*. Another school described re-referring to MASH with further evidence when in disagreement with MASH decision not to progress a referral through to assessment. However there was a lack of evidence of schools having escalated their concerns when a referral to MASH did not result in assessment and they remained concerned about a child.

10.8 Intervention and Review Outstanding was evident where School was effective in supporting a parent in the context of complex and multi-layered risks and concern to a sibling group. This included school liaising with the child's new school when there was a move to another borough to highlight the family's needs and the school relaying concerns both in written correspondence and through telephone follow ups.

11 Education Welfare Service (EWS)

11.1 One submission was received which reflected their involvement.

11.1.1 Recognition and Response was assessed as Good. School had referred to EWS at the earliest opportunity (the set criteria is a minimum of 12 unauthorised absences within a six week period).

11.2 The referral form identified safeguarding concerns and additional checks were undertaken with partner agencies via the CORE Panel. Neglect was considered as poor attendance can be symptomatic of neglect.

11.3 Voice of the Child Requires Improvement as more challenge is needed around the voice of the child being central within the school referral.

11.4 Case Recording Requires Improvement: The recording system has the ability to link referrals to the child however electronic storage facilities are not effective for this.

11.5 Assessment, Analysis, Planning No grading determined. The changing landscape of Education has impacted on service delivery. Early intervention and supportive work is only available to schools that choose to purchase that service (25% of schools have done so) otherwise schools deploy independent services.

11.5.1 Statutory service delivery responds to the offence that had been committed and not the ability of the parent(s) to change. A legal investigation of the parent takes place whereby officers will make referrals if neglect/abuse becomes apparent.

11.6 Intervention and Review No grading determined . A Penalty Notice was issued against the parent and was subsequently paid. The child is no longer of compulsory school age.

11.6.1 There was no overall grading however the auditor commented that the audit highlighted the need for greater awareness around assessment of neglect and or abuse issues within each case.

12. Bromley Children's Project (BCP) Early Interventions and Family Support

12.1 The analysis is of 4 detailed audits submitted by the Head of Service which reflected their involvement . Three cases were assessed as Good and one case was assessed as Requires Improvement.

12.1.1 Recognition and Response Cases assessed as Good evidenced clear well documented involvement with the family and strong multi -agency work eg TAC meetings swiftly convened in response to unfolding events.

12.1.2 Inadequate was characterized by failure to escalate decisions by MASH that threshold for assessment had not been reached despite well evidenced referrals to MASH detailing high levels of safeguarding concerns.

12.2 Voice of the Child Good evidence included children and young people whose views were strongly facilitated by the Children's Group Work Programme – (due to the nature of this programme there is recording of selective issues only).

12.3 Case Recording Cases assessed as Requires Improvement detailed the lack of a separate story for children and young people. The case recordings often focused on the parent'(s) narrative of their family life.

12.4 Assessment, Analysis, Planning Gradings ranged from Requires Improvement to Good. On some cases there was effective information sharing and partnership working between agencies such as multiple agencies working together to resolve the housing and debt issues - for one family this included BCP, Affinity Sutton, Housing and Bailiff. In other cases earlier and better communication and information sharing between agencies in the community would have identified significant concerns such as disguised compliance resulting in evidence based referrals to MASH at an earlier stage. There were indicators of disguised compliance where TAC meetings were repeatedly cancelled by parents: these meetings could have proceeded as professionals' meetings. TAC sometimes did not deal robustly enough with patterns of drift and delay.

12.5 Supervision and Management Good: Supervision demonstrated reflection and was outcome focused with the child's safety at the centre.

12.5.1 Management oversight around drift and delay was not always evident in supervision - New audit points have recently been added to case-working which will result in the audits of more open cases.

12.6 Intervention and Review Good - Planned interventions are based on the Signs of

Safety model- this utilizes a step by step approach which effectively sustains engagement with families working at their own pace. There is evidence of persistent tenacity and skilled work resulting in families achieving progress around identified goals.

12.6.1 Challenge to parents was also evident (eg reporting of illegal activity and referrals to MASH). Episodes of challenge were often the precursor for positive change after the challenges to the working relationship had been worked through – however challenging parents did not result in positive change for issues such as mental health. On some cases robust challenge was lacking to the parent.

13. <u>CAF Early Help</u>

13.1 CAF Team submitted 4 audits which reflected their involvement. Two cases were graded as Good. Two cases were not graded - CAF Team are not case holders and do not work directly with families which limited their responses to some of the audit questions.

13.1.1 Recognition and Response Good : Team Around the Child TAC meeting responded to risks and reduced concerns through multi agency work. The CAF team promoted agencies to support the family by providing appropriate guidance and input such as chairing TAC meetings on occasion where the Lead Professional has needed support.

13.1.2 Social Workers stepping down the CIN case by chairing the first TAC meeting has provided rigour to CAFs from the onset.

13.1.3 MASH requests for CAFs to be instigated were dealt with in a timely manner.

13.2 Voice of the Child No gradings determined. There is some evidence of the child's views being sought by agencies involved with the family however there is often not a clear voice of the child within the recording.

13.3 Case Recording Good – Recording is appropriate in terms of CAF Team input around process.

13.3.1 There were sometimes evidence of requests for CAF updates being sent out late without any explanation.

13.4 Assessment, Analysis, Planning Requires Improvement. There is some evidence of analysis according to the TAC meeting minutes around the effectiveness of actions set. On other cases CAF actions need to be SMART with clear objectives especially in terms of on-going neglect.

13.4.1 A recurrent theme was the Lead Professional not responding to requests for updates so a lack of clarity as to whether the case was active or whether drift and delay had set in. The CAF team can provide support when there are problems but this is not regularly taken up.

13.4.2 Closures are not always completed whereby there is no outcome summary. The CAF closure form needs to be utilized which may elicit better quality information and opportunities for reflections around progress made against each identified goal.

13.5 Supervision and Management Requires Improvement: CAF's evidenced appropriate referrals to MASH however when the CAF Team do not agree with the MASH outcome of CAF / BCP referrals this needs to be clearly evidenced in records with consideration around escalation.

13.6 Intervention and Review Good There is evidence of cases where regular reviews have taken place on complex cases supported by the CAF Team who have intervened where necessary to promote an ongoing process of review.

14. Children's Social Care

14.1 The analysis is based on 10 audits. Work completed by the MASH team was usually the focus of auditing however some cases went on to receive further services from CSC within the audit timeframe so the totality of case work was audited. Overall grading were 2 cases graded as Inadequate and 8 cases graded as Requires Improvement.

14.1.1 Recognition and Response was assessed as Requires Improvement: Key areas of risk were identified and assessed but regularly required a more thorough approach in information gathering including accessing information from the most appropriate agencies in particular from GPs for parental health related issues and discussions with referrers. Information was also not requested from previous Local Authorities in one case despite awareness that assessments had been undertaken and in the context of a multiplicity of risks. Historical themes and patterns from previous referrals did not always appear to inform the assessment process.

14.1.2 The quality of information provided by partner agency at times impeded thorough assessment – there was sometimes a lack of good quality contemporaneous network information.

14.1.3 Lengthy delays to processing referrals were evident on occasion whereby risks were not assessed or managed.

14.2 Assessment, Analysis and Planning Cases graded as Good demonstrated well written evidence based assessment and analysis, critical awareness of the limitations of the assessment and plans including contingency planning.

14.2.1 The majority of cases were assessed as Requires Improvement. Referral outcomes sometimes demonstrated an over reliance on existing CAFs with a paucity of information as to the quality, effectiveness and rigour of the CAF. Reflection and analysis was lacking as to why an outcome decision was to continue with a CAF when

there was evidence that previous episodes of work had not achieved the desired outcome within the CAF framework. On some cases there was evidence of effective transfer of information from MASH to CAF which added rigour to the CAF process.

14.2.3 Practitioners commented on the time constraints and competing priorities around processing of referrals which resulted in limited efforts in relation to contacting parent(s) or partner agencies impacting on the quality of their assessments. Reflections included the benefits of more pro – active attempts to include parent(s) and professionals which would result in better assessments.

14.2.4 A recurring theme was the lack of interrogation or critical analysis of parent'(s) self reporting together with an absence of cross referencing with past history or with the perspective of other agencies. There was also little evidence of critically analysing the information in terms of the likely impact on the child.

14.2.5 In cases where the assessment recording was mainly based on the parent'(s) perspective, the rationale appeared to lack rigour which undermined the cogency of the outcome decisions. An example was parents refuting concerns resulting in an outcome of No Further Action. There were very few details evidencing the weight given to the parents' denials (or outlining protective factors) which underpinned the decision making process. Audit submissions from child facing agency provided an additional perspective for cross referencing these cases: this additional perspective did often cohere with the outcome decision highlighting that the deficits lay within the evidence basis and critical analysis of the assessment rather than the outcome decision.

14.2.6 There was a lack of expertise around substance misuse eg consideration of hidden harm to children and young people and indicators of relapse in parents.

14.2.7 Risk was inadequately assessed where threshold had been reached for CSC assessment with compelling evidence from CAF and a range of agencies detailing escalating crisis and ineffective safeguarding however cases had not been

progressed for referral. There was also a lack of assessment of how each child within the household would be effected by the risks.

14.2.8 On 2 cases (a MASH assessment and a Social Work assessment) there was a concerning transposition of information which distorted the risk profile. Information appeared to have been re-configured to fit the rationale whereby risk was downgraded. This is especially concerning as erroneous interpretation of risk can become embedded into the narrative of a case so has the potential to impair future risk assessment.

14.3 Voice of the Child Requiring Improvement in the majority of cases. MASH team do not have any contact with children and young people so network information together with parent(s) views provide a sense of the child's experience. The focus on adults sometimes obscured the experience of the child in recordings and it was not evident that practitioners had asked questions to gain a sense of the child's experience.

14.3.1 In one case there was some excellent work with clear detailed recordings of the child's views with comments around the context and links made to the child's behaviour. A hypothesis around the child's experience was formed at the centre of the CP process making the connection between the manifestation of emotional and behavioural difficulties with neglectful/ abusive parenting.

14.3.2 Voice of the child was assessed as Inadequate when children's voices did not emerge despite opportunities for direct work and network information. There was an absence of exploring children's experiences of emotional abuse through exposure to parental substance misuse and domestic abuse: it was not clear whether the social workers had skills and guidance around this type of direct work

14.4 Record keeping Required improvement for the majority of recording. The narrative flow was clear however the brevity of the recording style lacked sufficient details and context. The majority of recording consisted of a summary of conversations

with parents where there was little evidence of analytic or reflective content. There were sometimes gaps in the recording process with no comments as to why information has not been obtained or followed up.

14.4.1 Inadequate recording included key details of children's addresses not being updated when they moved between extended family households and no recording of parent's partners and addresses. ID details around names are essential information and need to be updated. Disability information is not regularly recorded as the Guardian database does not collect this data and it needs to be updated separately on CareFirst.

14.5 Supervision and Management Good cases demonstrated thorough analysis and actions including challenge around incomplete actions and was effective at navigating the developing issues within the case.

14.5.1 Requires Improvement- All cases evidenced some management oversight but this sometimes lacked depth around critical analysis and did not evidence challenge around deficits in assessments. Management rationale demonstrated an implicit recognition of risk however this needed to be more explicit to have greater impact on planning eg early intervention support services / substance misuse.

14.5.2 There was no evidence of ad- hoc supervisions being recorded despite the advice seeking and direction which occur throughout case working,

14.5.3 Inadequate cases evidenced failure to respond adequately to risk around threshold for assessment for two out of ten cases especially where there were escalating crisis including acute risks to young children within the sibling groups. Proportionality around volume, complexity and density of risks should always inform decision making around thresholds.

14.5.4 No management comments or guidance were evident for a case which had progressed to assessment including at the point of case closure. There were obvious

deficits in the social work assessment which could have been rectified by effective management guidance and directions to address the deficits.

14.6 Intervention and Review Requires Improvement: There were missed opportunities around early intervention on cases where the threshold was not met for assessment but there were vulnerabilities around re-referral. There was no evidence of discussion of CAF with these parents or other forms of early intervention such as relapse prevention work.

14.6.1 There was a lack of evidence of key information being sent to agencies as part of closure processes to ensure that other agencies were equipped to manage current risks. Scanned documents did not regularly evidence this type of correspondence despite the complex and high levels of risk on case closure for some children such as families moving between boroughs.

14.6.2 Inadequate intervention demonstrated the likelihood of exposing children to further neglect and abuse and an increase in known episodes of neglectful parenting through failure to progress cases to Referral and Assessment.

15 Police

15.1 Two submissions were received which reflected their involvement. The 2 cases had police contact from a combination of uniformed officers, MASH and CAIT officers. The variety of information systems used by the police may have impacted on the information available to audit.

15.1.1 Recognition and Response Good: All Merlins were shared with CSC promptly. They identified risks to children and planning around the risks. Some Merlins needed to record that parents had been informed that the police information would be shared with CSC.

15.2 Voice of the Child Requires Improvement: A CAIT CRIS document did not capture what the child said to the police in the Section 47 investigation but did contain the original disclosure the child made to a teacher and a CP Plan.

15.3 Case Recording Good: The quality of recording varies from a good standard accurately reflecting the status of an ongoing investigation to average recording with not enough detail.

15.4 Assessment, Analysis, Planning No gradings determined: Police procedures were followed with effective information sharing and assessment.

15.5 Supervision and Management No gradings determined: Reports were supervised and decisions noted and appropriately updated in regards to a rationale.

15.6 Intervention and Review: Good. A parent was arrested, interviewed and cautioned for assault on their child.

15.7 The challenges of dealing with young people who present with a lack of remorse for criminal actions was noted.

16 Youth Offending Service (YOS)

16.1 One detailed submission was received which reflected their involvement.

16.1.1 Response and Recognition There is good evidence of working collaboratively within YOS with the Substance Misuse Worker.

16.1.2 This section had been assessed as Inadequate due to the deficits in joint working between YOS and partner agencies and between YOS and the parent which meant that there were missed opportunities around the intervention. The sharing of information in a timely fashion would have enabled better insight into the family circumstances

which was an important context of the offences (offences were linked to the families' poverty).

16.1.3 YOS did not request information from Children's Social Care or school. There is no evidence of the TAC meeting minutes which YOS had attended. A referral to CAMHS was made in response to concerns around depression but was not followed up. There had been little attempt to involve the parent in the YOS intervention work.

16.2 Voice of the Child This was assessed as Requires Improvement as whilst key aspects of the Young person's experience were recorded such as feelings of depression and futility together with observations of the young person regularly wearing the same clothing this needed further exploration together with action around pursuing the CAMHS referral.

16.2.1 There was good use of an interpreter to initially engage the parent(s). However it was unclear whether there had been sufficient efforts to convey the serious nature of the young person's behaviour and to support the parent(s) in participating in the YOS intervention. Language differences may have been a contributing factor – an interpreter should have been used.

16.3 Record Keeping Requires Improvement: case records are inconsistent in their summary of work in sessions with the young person.

16.4 Assessment, Analysis, Planning Inadequate assessment as the ASSET assessment is not explicit in terms of the risk posed by the young person or the protective factors that are in place. There is also no evidence that inter-agency working and participation in CAF has informed the Plan or Intervention.

16.5 Supervision and Management Effective case management is evident where reviews entail the identification of assessments that are required to be completed and comments on issues relating to enforcement/compliance where the young person has failed to attend appointments and follow up action have not been undertaken.

16.5.1 Inadequate Supervision has little evidence of effective management oversight which should have identified deficits in the assessments and tracked the progression of the work completed.

16.6 Intervention and Review There is no evidence that the young person has re-offended in the year that has elapsed since the completion of the intervention.

16.6.1 Reviews have been Inadequate as there is no evidence that there have been any clear outcomes outlined for the young person and whether these have been met and analysis on the impact of these on the young person's future offending behaviour.

16.6.2 The overall grading was Inadequate due to the lack of quality assurance, supervision and management oversight: the auditor commented on the need for all case workers and managers to have a consistent awareness of what constitutes adequate and good quality practice.

17. Housing

17.1 Two detailed submissions were received from Housing which reflected their involvement. The overall gradings were Requires Improvement.

17.1.1 Recognition and Response was graded as Requires improvement and Inadequate. A family were temporarily housed (following eviction from private housing) in a nightly paid provision (i.e. B and B) for four months which is longer than the Government recommended six weeks. The most appropriate placement according to the presenting issues will be subsumed by what is best available on the day. Records evidenced no concerns being shared by other agencies.

17.2 Voice of the Child Requires improvements as the severe lack of appropriate resources in borough impacts on attempting to meet all needs other than basic homelessness.

17.3 Case Recording Requires improvement as there is no cross referencing between Housing and CSC records around safeguarding concerns or vulnerabilities.

174 Assessment, Analysis, Planning Requires improvement as staff collect information but do not realize the safeguarding implications so do not take appropriate action. There is also a lack of information sharing when families move out of borough and the risks are not followed through.

17.5 Supervision and Management Requires improvement. Casework supervision and authorization to accept a statutory duty was signed off by a Team Manager. IT recording systems could be a lot better and are in the process of being updated.

17.6 Intervention and Review Requires improvement as Housing failed to refer to MASH when they were informed by a parent that a child returned to live with the violent parent following re-housing due to fleeing Domestic Violence. Housing were also aware of additional vulnerability in terms of significant disability and emotional health issues within the family.

18. Summary

18.1 This audit focused on children and young people who were bordering on the threshold for CSC assessment for neglect. A small number of cases evidenced a high degree of coherency amongst agencies around the balance of safeguarding concerns and protective factors whereas some cases evidenced a wide spectrum of perspectives. Many of these cases were supported by agencies in the community and some cases had had significant amounts of support and intervention intermittently over the years. The audit evidenced that whilst most children experiencing neglect are

being recognised across agencies there continues to be some types of neglect which is more difficult to identify where children's needs are obscured such as Hidden Harm and chronic neglect. A risk assessment tool may assist with identification , consistency and a structured approach around neglect planning.

18.2 The challenges around identification and intervention indicate the need for stronger management oversight in particular around reflective supervision and risk management. Support and guidance for practitioners are particularly important around the recurring themes of the child and siblings being kept at the centre of practice and critical thinking around the parent'(s) narrative.

18.3 Some agencies work autonomously and have limited access to consultation or supervision which increases the challenges around safeguarding.

18.4 There were many examples of effective communication between agencies however deficits in proportionate and relevant information sharing were evident throughout the layers of networks. There was an absence of connectivity with GP's in particular who are partners in safeguarding and need to be included in information sharing at all levels including at CAF level.

18.5 The audit evidenced many examples of committed and skilled partnership work varying from CAF plans to work taking place within school systems. This included skilled and thoughtful work around children with disabilities. Some of this work was focused around goals and outcomes however in other cases drift and delay may have diluted the outcome focused planning and there needs to be a continued focus across agencies on measurable milestones that reflect observed improvement in the child.

18.6 Neglect rarely exists in isolation and substance misuse particularly around alcoholism featured in several cases. Expertise around specialist areas such as substance misuse and domestic abuse needs to improve across agencies and there was an absence of promoting early intervention in these areas so service users have an informed knowledge of what services are available and the way in which they can be of benefit.

18.7 MASH audits evidenced some cases which demonstrated effective risk assessment and management. However there were some cases where threshold had been reached for assessment and children should have been progressed through to Referral and Assessment at an earlier referral point. These were cases where there were existing CAF plans or where there had been repeat referrals.

18.8 Children and young people with chronic patterns of neglect can be more difficult to identify as professionals become habituated to the neglect characteristics as ingrained to a particular child and or family. Chronic neglect in families can also be particularly demanding to work with over extended periods of time manifesting in a lack of professional curiosity especially when practitioners have limited support and guidance.

18.9 There was no evidence that any agency utilized the BSCB escalation policy around MASH's decisions not to progress some of the cases to referral irrespective of the strength of the multi agency evidence basis . There was limited evidence in general around dissent or challenge within or across professional networks. It is essential that partner agencies utilize the escalation policy when they remain concerned about a child including as result of a threshold decision made by the MASH team.

19. Recommendations

Multi Agency

1/ Neglect Risk assessment tool to be implemented across agencies to promote identification and outcome focused planning around neglect.

2/ BSCB To ensure that all agencies are aware of the escalation process and how to use it to escalate a disagreement around a referral threshold decision by MASH.

3/ BSCB To consider providing training around multi – agency auditing to promote quality assurance processes within and across agencies.

MASH Recommendations

1/ MASH to update procedures around information sharing to include guidance on when to request network checks from GPs and proportionate information sharing.

2/ Ad-hoc supervision to be recorded by Practitioners/ Managers to evidence response to unfolding events.

3/Disability needs to be routinely completed on CF/ Eclipse record as Guardian database does not capture this information.

4/ Strategies to be considered to improve expertise around Substance misuse eg the use of consultations with specialist agencies.

GP Recommendations

1/ Analysis of parenting capacity around the effect of parental mental health and parental substance misuse on the child to be included in the recording of consultations

2/ GPs to code family records around vulnerabilities to assist with identification of safeguarding concerns/ support needs .

Health Visitor & School Nurses Recommendation

1/All families of concern to include recordings of outcomes of MASH referrals and Plans of work.

2/ All CP cases & cases with a neglect history to be discussed in supervision & supervision record completed.

3/Use of chronology to be promoted for cases with a history of neglect for transition to the School Nurse Service .

4/ Cases which are affected by drift & delay to be presented to Vulnerability Panel to discuss.

BDAS Recommendations

1/ Home visit assessment must be signed by both workers attending the home and the lead worker to inform key partners of the outcome verbally or written within a timely fashion agreed by senior management

2/ Staff to attend workshop/training that explores professional conversation around family history & circumstances that impact the outcome of the child - Staff to attend Safeguarding Proffessional curiosity training if last training attended more than 2 years ago Care coordinator & Recovery Worker Every 2 years.

3/ Staff to utilise the quality standards cycle and audit one file per pod monthly and feedback to be discussed within pod meeting for reflective learning

4/ Review current local agreements for information sharing with key agencies, in particular children's social services, within the referral and assessment team and those on higher threshold.

EWS Recommendation

1/ Referral Form to expand on and identify potential CP concerns.

CAF Recommendations

1/ The use of TAC meetings to be promoted within 3 months e.g. when minutes received do not specify a review date CAF team to contact the Lead Professional for a meeting date to be identified.

2/ The decision to challenge / not to challenge to be clearly recorded on EIS in the event of differences of opinion around threshold decisions made by MASH.

YOS Recommendations

1/ Manager training in being able to assess sufficiency of practice and support staff to reach this level.

2/ Staff given clear direction on recording practice to achieve greater consistency across practitioners.

Housing Recommendations

1/ Mandatory Safeguarding training for all Housing staff.

2/ Team/Service inductions to enable a better understanding of each other's services, responsibilities and challenges.

20. Glossary

BSCB - Bromley Safeguarding Children Board

CAF – Common Assessment Framework

CAIT- Child Abuse Investigation Team

CAMHS- Child and Adolescent Mental Health Services

CHIN -Child in Need

CP- Child Protection

CSC- Children's Social Care

EIFS- Early Intervention and Family Support

ICS - Integrated Children's System

MASH – Multi Agency Support Hub

QAPM – Quality Assurance and Performance Monitoring Sub Group (of the BSCB)

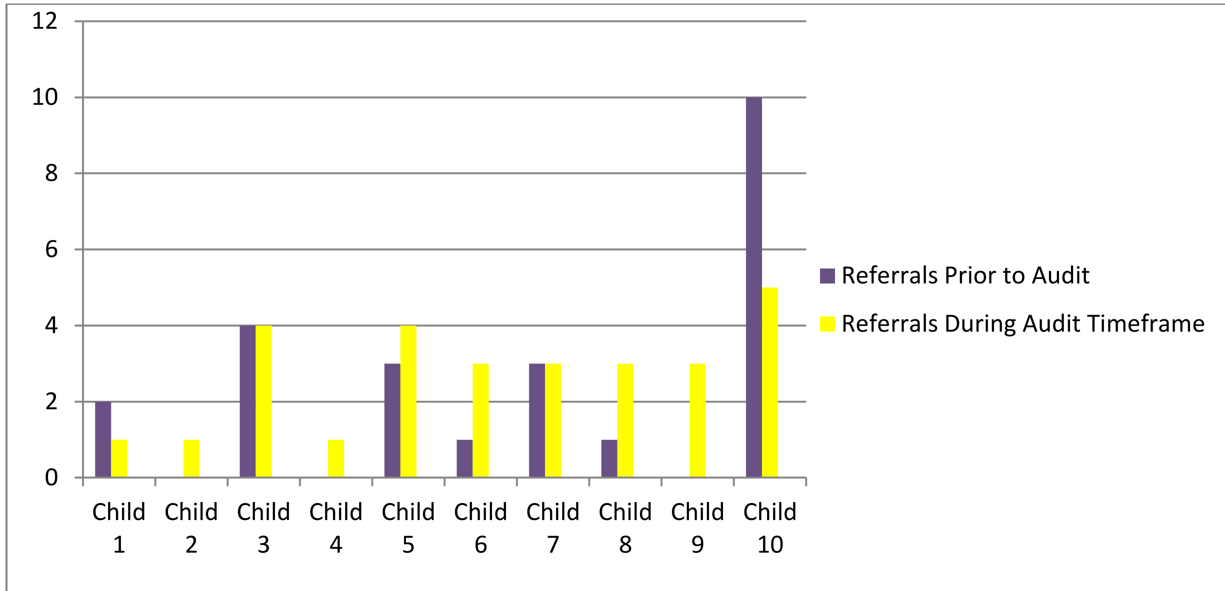
R & A- Referral & Assessment Service

TAC- Team Around the Child

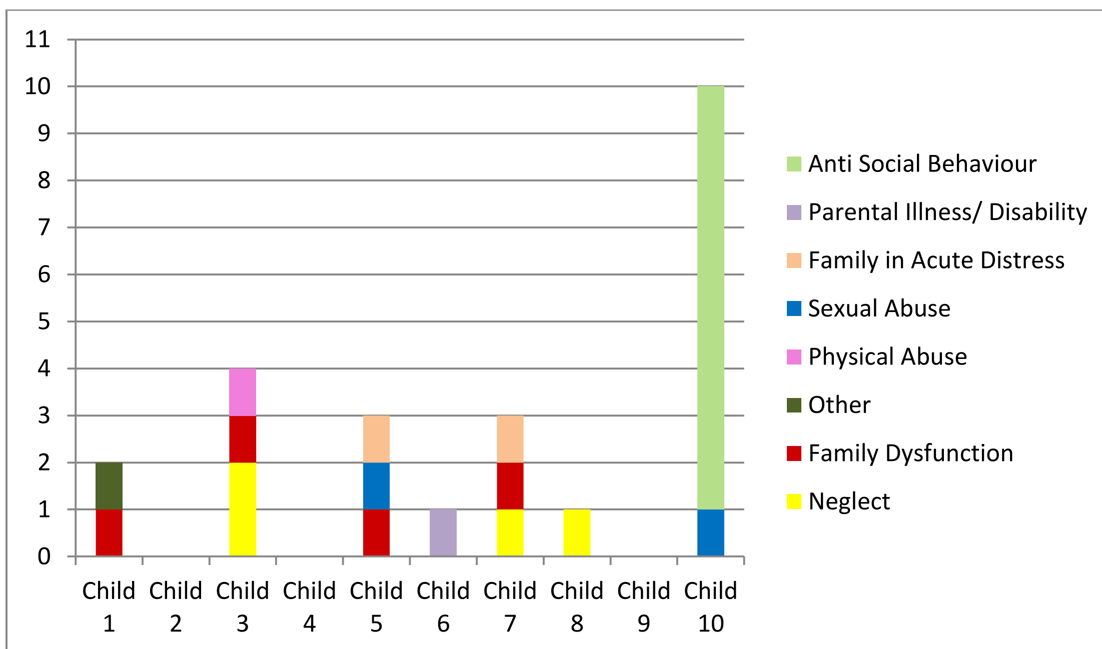
YOS- Youth Offending Service

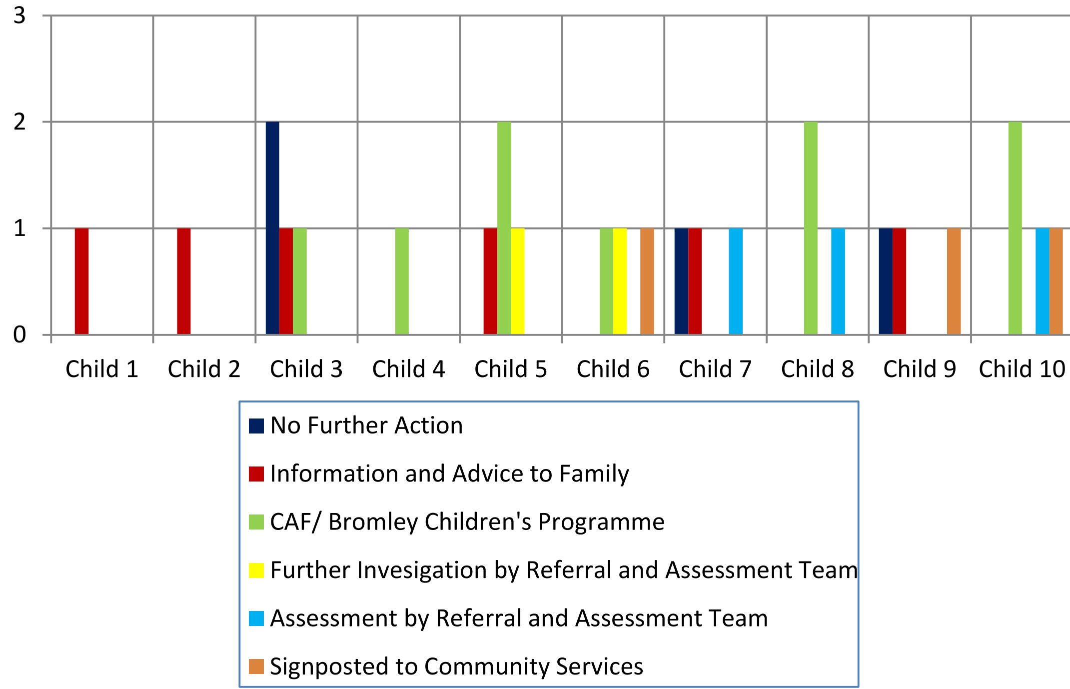
Appendix 1

Referrals received prior to audit period and during audit period



Categories of referrals received prior to audit period




Outcomes of referrals made during the audit period
3
2
1
0
Child 1
Child 2
Child 3
Child 4
Child 5
Child 6
Child 7
Child 8
Child 9
Child 10
No Further Action
Information and Advice to Family
CAF/ Bromley Children's Programme
Further Invesigation by Referral and Assessment Team
Assessment by Referral and Assessment Team
Signposted to Community Services

Appendix 2

CASE NO.	AGE & GENDER	OUTLINE ISSUES
1	2 M	• Concerns about mother's partners use of substances & domestic abuse • Mother had substance misuse problems Pre- birth
2	9 F	• Child exposed to current Parental Alcohol Misuse • Past history of serious alcohol misuse
3	10 M	• Extensive history of neglect & large sibling group – multiple referrers • Domestic violence witnessed by professionals • Physical abuse • Neglectful care by extended family (in addition to parental neglect) • Medical/ Dental neglect of older sibling • Exposure to criminal violence within extended family
4	12 F	• No previous referrals however previous assessment of a family member. • New secondary school placement, low school attendance, parent avoidant of professional contact.
5	5 F	• Family received CSC services in another LA. • Mother's previous relationships all characterised by serious domestic violence. • Referral for non recent sexual abuse by father to sibling. • Children exposed to domestic abuse. • Gang related threats of violence to family – sibling with gang associations • Parent with serious physical health condition. • Parent relies on violent ex partner to contribute to the care of children
6	8 F	• Pre birth serious substance misuse by both parents • Parental mental illness, mother disengaged from psychiatric services – child exposed to suicide ideation • Current mental health crisis, alcohol misuse • Historical concerns of sexualised behaviour of the child to another child. • Domestic abuse within Mother's previous relationships • Social and communication difficulties of child with some concern around mental health.
7	11 M	• Disability within sibling group • History of parental alcohol misuse, domestic abuse • Children exposed to parental alcohol misuse • Separation of parents & concern that child is living with non protective parent.
8	7 M	• Developmental delay & disability • History of chaotic parenting, lack of supervision and stimulation, missed health appointments and poor nursery attendance • Physical abuse to child from extended family • Anonymous concerns around unsuitable living conditions. • New pregnancy • Concerns around child's hygiene
9	13 M	• Children exposed to domestic abuse. • Malicious allegations of physical abuse by father to mother in the context of an acrimonious separation. • Father – mental health issues • Child left home alone

10	16 M	• Prolific missing episodes of sibling • Sibling - Gang association, CSE, substance misuse & mental health • Poor behaviour, truanting , some missing episodes, anti social behaviour, offending including criminal violence. • Violence from sibling towards mother & index child • Poverty related issues. • Child Left home alone.