Learning Together: Staff Briefing

How do we know we are working together well to safeguard children & young people?

This short briefing is aimed at professionals who work with children and families in Brighton & Hove. It presents the key findings and recommendations from a recent multi agency Deep Dive audit on **Children with Disabilities**. A full report is also available for professionals working in partner agencies in Brighton & Hove upon request. If you would like a copy of this report please contact us at BHSCP@Brighton-hove.gov.uk

Safeguarding Children with Disabilities

Research has found that disabled children are three to four times more likely to be abused and neglected than non-disabled children (Jones et al 2012; Sullivan & Knutson 2000); and are more likely to experience multiple types and occurrences of abuse (Sullivan and Knutson 2000) and have a prevalence rate of 20% for experiencing physical violence, 14 % sexual violence, 18% emotional abuse and 9.5% for neglect (Jones et al 2012).

The Ofsted Thematic Inspection Report: Protecting Disabled Children, August 2012 considered the effectiveness of child protection work for disabled children in 12 local authorities, examining 173 cases and tracing the child's journey through the system to understand how well disabled children are protected from harm. The report found that child protection concerns were not always clearly recognised or dealt with early enough, and decisions and assessments did not consistently taking into account historical concerns. Another finding of the inspection was that most local authorities and LSCBs did not have a clear understanding of the quality of child protection work with disabled children and the impact of this on keeping them safe.

A multi-agency audit was completed in October 2017 which examined whether a robust and timely service is provided to disabled children who are in need of protection and whether we are making a difference.

Overall Judgements

The final judgements for the cases rated the audits as 'Good' (6), Requires improvement with good features (1) and requires improvement (2).

Methodology

This was an audit of nine cases – children with disabilities who are subject to a Child Protection Plan (stepped up in the last 12 months). The sample included a mix of ages, gender & ethnicity.

The auditing team comprised of representatives from the following agencies:

- Children's Social Work
- Sussex Police
- Sussex Partnership NHS Foundation Trust (CAMHS, Adult Mental Health)
- Sussex Community NHS Foundation Trust (School Nurses & Health Visitors)
- Clinical Commissioning Group (General Practitioners)
- Brighton & Sussex University Hospitals (BSUH)
- Brighton & Hove Schools
- The Joint Domestic, Sexual Violence & Abuse and Violence against Women & Girls (VAWG) Unit

Altogether, 52 audit forms were submitted for 9 children.

As with previous audits agencies completed audit tools separately and were then brought together in a moderation day chaired by the Head of Safeguarding and Performance, Brighton & Hove City Council.

What is working well?

In all cases child protection concerns were identified early and there was a prompt response by the professional network.

In all cases the assessment (social work) addresses the cumulative impact on the child and the parent's capacity and motivation to change.

In all cases there was a good awareness and understanding of safeguarding by staff working with children with disabilities in their identification and response to child protection concerns. It was clear that thresholds for child protection are understood.

Where a s47 investigation was required there was evidence of appropriate consultation with all of the relevant agencies about the investigation and its issues.

In the majority of cases the assessment took into account the impact of the child's disability on their siblings and overall family functioning. There was good analysis of the family situation and appropriate consideration given to historical information and previous concerns.

In the vast majority of cases children have plans which are sufficiently focused on outcomes, identify risks effectively and ensure the child's safety.

The professional network communicated effectively with the child and family, and with one another, in 7/9 cases.

In 7/9 cases there was effective information sharing and joint working. Of note, is the effective working relationship between social work and the child's school (including the school nurse in some cases).

In 8/9 cases good progress has been made in tackling the identified child protection risks effectively and ensuring the child's safety – this includes four cases which have been stepped down to Child in Need and one case which has been closed.

Five out of six parents rated the help that they have received as 'good' and felt that things had improved for them and their children.

What do we need to improve?

In three cases not all of the appropriate agencies contributed to the strategy discussion.

In three cases Core Group/Network meetings were not held within the timescales – this relates to two cases where the child was subject to a CIN Plan (both held by locum workers).

In one case 31 professionals were listed in the Initial Child Protection Conference as being involved with the child and their family. There was some confusion about who was attending he Core Group, with professionals assuming that someone else from their agency were dealing with the case. To complicate matters further, there was a lack of agreement between the professionals and family about the best way forward for the child.

There is wide variation in how well the voice of the child is heard. - in two cases there was too much of a focus on the parents' needs. In another case the older sibling's voice can often dominate the records.

LSCB Multi Agency Training:

The LSCB offers a day long course on Safeguarding Children with Disabilities and the next session takes place on **Thursday 22 March 2018**. This training will help you identify the factors that make children with disabilities more vulnerable to harm; describe the attitudes and assumptions that can exist in relation to children with disabilities suffering from abuse and neglect; improve your understanding of multi-agency roles in safeguarding children with disabilities; and gain practice skills in communicating with children with disabilities when investigating abuse or neglect

Book through the Learning Gateway here or visit the LSCB Website for more information: www.brightonandhovelscb.org.uk/events

What Next?

The areas in need of improvement have been considered by the audit group and the following recommendations are made:

- In cases where numerous health professionals are involved with the child and family, a lead paediatrician is required to provide an oversight of all of the medical conditions, interventions and outcomes and to prepare a robust health report for the CP Conference.
- All of the main health providers (SCFT, BSUH, SPFT) to indicate how they will address the identification of lead clinicians in safeguarding and child protection cases, and in particular perplexing fabricated or Induced illness cases.
- Staff to be reminded that the social worker and their manager, health professionals and a police representative should, as a minimum, be involved in the strategy discussion.
- All agencies to ensure that the voice of the child is heard (as evidenced through direct work, communication and/or observation, or through discussion with those that know the child well).
- Each agency involved in the audit to share and embed the learning with front line staff and report back to Monitoring & Evaluation Subcommittee on progress
- Ensure that the learning from this report is shared with the LSCB Learning & Development Subcommittee so that it can be embedded into the learning offer.

Further Reading & Useful Links

- **Pan Sussex Child Protection & Safeguarding Procedures**
- **Ofsted, Protecting disabled children: thematic inspection, August 2012**
- **NSPCC – How organisations can safeguard deaf & disabled children** and their summary of **Learning from National Case Reviews**
- **Amaze** gives information, advice and support to families of children and young people with special educational needs and disabilities (SEND) in Brighton & Hove and Sussex. They also support young people with SEND up to 25
- **Triangle** provides skilled support for children and young people in different settings including legal proceedings and enables children's communication when it matters most, for example when children or young people's evidence is required by the courts, when their views are needed to inform decisions about their lives, and when adults are trying to understand and respond to concerning behaviours.

If you are concerned about a child in Brighton & Hove contact the
Front Door for Families on **01273 290400**

You can also complete their online referral form or email FrontDoorForFamilies@brighton-hove.gov.uk

Feedback

We would like to hear your thoughts, feedback & comments on findings presented to you in this briefing and any feedback on the style of the briefing itself.

Please contact us at BHSCP@Brighton-Hove.gov.uk to ensure your voice is heard.

@BrightonHoveSCP