



Bedford Borough
Safeguarding Children Board

**Thematic Serious Case Review
Neglect and Disability**

OVERVIEW REPORT

'Children First'

Publication on the 23rd May

Lead Reviewer

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Acknowledgements

I am exceedingly grateful for the support and insight of those who gave their time, expertise and knowledge to support this thematic serious case review (SCR). This includes the senior leads who contributed via the SCR panel and the frontline staff and their managers who attended the learning and improvement events. I would especially like to acknowledge the support of the Business Manager of the Bedford Borough Safeguarding Children Board (BBSCB), who together with the Chair and Secretary of the Board, provided invaluable assistance in the commissioning and conduct of this review.

Most importantly, I would like to thank the families that so generously contributed to this review. This includes representatives of the Bedford Borough Parent Carer Forum, who advocate for the very best care for all disabled children and their families in the locality. It also includes parents from two of the families whose cases were audited as part of this review. Their experiences are both grounded and enlightening.

Governance

My credentials as an independent author and reviewer are that I am currently working as a freelance Safeguarding Children Consultant after a long career in the public sector. I am registered as a general nurse, children's nurse and health visitor with the Nursing and Midwifery Council. I have prior experience as an author of a number of single agency internal reviews, an independent author of commissioned single and multi-agency learning and improvement case reviews and a number of service reviews.

I declare that I have found no conflict of interest in undertaking this review and am independent to the BBSCB and partner agencies. The report has been commissioned by, and written for, the Board. In reflecting the importance of accountability to the wider public the report will be published on the BBSCB website. As such, the details of individuals providing or receiving care have been anonymised in accordance with statutory guidance and best practice.

Note on terminology

The report uses the term 'children' to refer to those aged under 18 years as reflected in legislation and statutory guidance. Reference to 'parents' may include those who are parent carers for children.

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1.0 Background and purpose

1.1 This independently-led thematic serious case review (SCR) was commissioned by the Chair of Bedford Borough Safeguarding Children Board (BBSCB) in October 2015, following discussion at the BBSCB Serious Incident Review Group (SIRG) the previous month. The review complements, and is published alongside, the BBSCB Patrick SCR.

1.2 Whilst drawing on the learning from Patrick, the commissioning of this review is underpinned by the death of Tomas, also a teenager with complex health needs and disabilities, who died unexpectedly in 2014. The circumstances and learning from Tomas's death mirror, in part, Patrick's case; with evidence of long-standing neglect of health care needs. Tomas may have additionally experienced the 'double discrimination' (Murray and Osbourne, 2009) of being a disabled child from a minority ethnic group.

1.3 BBSCB had expressed their concerns about the number of serious incident notifications involving children and young people with complex disabilities (including those who had died) in their Annual Report for 2014-2015 (BBSCB, 2015a). The Board also signalled their intention to seek further reassurances that disabled children and young people are now effectively safeguarded and protected from harm.

1.4 The over-arching purpose of this thematic serious case review is thus to respond to the following question, posed by the BBSCB SIRG:

'What is the quality of the current professional recognition and response to disabled children and young people where neglect may be a feature?'

1.5 This SCR takes forward the themes identified in the above cases and builds on the learning through audit and review of a further six cases involving disabled children and families, currently receiving care from local health, education, social care or voluntary sector services.

1.6 The fact that a Children's Improvement Board had been established in Bedford Borough in 2014 to oversee continuing improvements in children's services, most especially in the quality and practice of children's social work, is an important backdrop to this review.

1.7 The Terms of Reference (ToR) for the SCR can be found in Appendix One. These highlight areas for enquiry, including; evidence of good practice, child-centred practice, the meaning of disability for the child, family and practitioners, the recognition and response to neglect, support for parents and parenting and the provision of services to children and young people with a disability.

1.8 The lead reviewer has been competently supported by a multi-agency Thematic SCR Panel, as outlined in the terms of reference, as well as by the BBSCB Chair. We have aimed to address the core requirements for the conduct of reviews set out in statutory guidance.¹ These include the need to be mindful of the complexities of multi-agency safeguarding children work; avoiding the use of hindsight and making use of research and case evidence to inform the findings.

¹ see HM Government (2015) page 74

1.9 The contribution of practitioners and their managers is fundamental to the review. This has been both collaborative and reflective. As such, much of the learning shared in this report should be considered as being 'co-produced'.

1.10 The views of families with disabled children who are accessing local services are also critical to the learning from this review. Their experiences are acknowledged as being both powerful and grounded.

1.11 The next section describes the methodology adopted for the review. This is followed by a description and analysis of the emergent issues for practice and policy. The report concludes by raising a number of key learning points and questions for the Board. The aim has been to meet the brief for a 'concise overview report' that informs learning and improvement for children's services into the future.

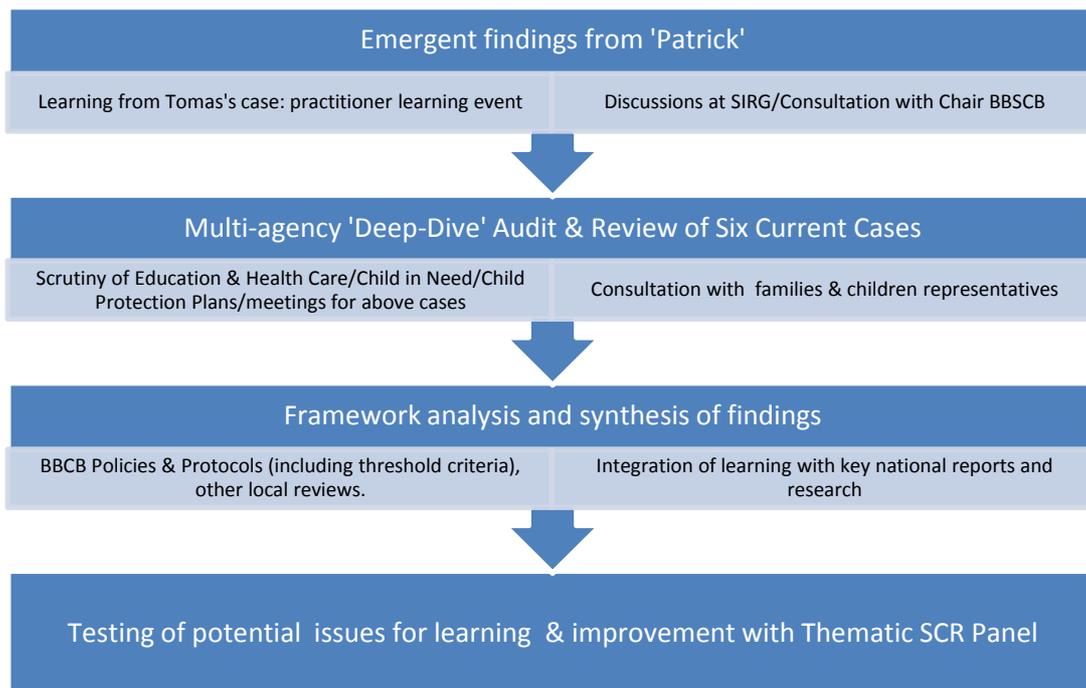
1.12 It is therefore anticipated that the collaborative learning that this review has engendered may be used to improve the daily lived experiences, health and welfare of disabled children and their families, as well as other children and young people with additional needs in Bedford Borough.

2.0 Methodology

2.1 This thematic SCR has adopted a bespoke 'learning together' approach that broadly reflects the use of systems methodology recommended by statutory guidance and reviews (Fish *et al.*, 2008; Munro, 2011; HM Government, 2015). This approach recognises the context in which individuals practice, and offers a greater potential for learning and improvement to be embedded at a number of levels.

2.2 Given the additional complexity created by the requirement to consider the systemic learning from the cases in which children have died, as well as the quality of the *current* professional recognition and response to disabled children and young people where neglect might feature, a mixed methodological approach has been taken.

2.3 This approach is summarised diagrammatically below. However, it should be noted that the process was not entirely linear. There was a need to revisit different elements of the review in order to triangulate the emergent findings and to ensure that the potential for learning and improvement was rooted in the evidence-base.



2.4 The emergent findings from the Patrick SCR were shared with the lead reviewer (CP) at the outset of the current review. The learning from Tomas's case evolved in a small-scale practitioner learning event held in November 2015. This was attended by managers and practitioners from health care providers and children's social care. Apologies were received from education colleagues and the GP. The event was facilitated by the lead reviewer and supported by the BBSCB Business Manager and Secretary. Disciplines represented included specialist school nursing, physiotherapy, dietetics, paediatrics and social work. It is understood that Tomas's family have moved back to their country of origin and were not able to be contacted as part of this wider review.

2.5 The learning from Tomas's case has been fundamental to the commissioning and conduct of this review. However, because the case is 'historic' rather than 'current' the detailed reporting of the findings is outside of the Terms of Reference.

2.6 The multi-agency 'deep dive' audit and case discussions took place over two days, the 18th and 19th January 2016, with three cases subject to review on each day. Parents and carers were informed of the audit and invited to meet separately with the Lead Reviewer. The meetings, involving two mothers, and a social worker (for one of the families), took place on 15th March 2016.

2.7 In addition, a face to face meeting and a telecom were held with representatives of the Bedford Borough Parent Carer Forum. This helped to ensure a 'father's voice' could also be reflected in the review.

2.8 The audit was guided by an adapted version of the Bedford Borough Children's Services Audit Tool (as agreed by the Thematic SCR Panel). The adaptations reflected the need to focus on the themes of disability and neglect, but also embraced the emergent

learning from the Patrick and Tomas reviews. A copy of the audit tool is provided in Appendix Two.

2.9 The six cases that were reviewed were selected on the following criteria, agreed by the Panel:

1. The child lives in Bedford Borough, has a known disability, and the child (and/or their family) are currently receiving services from one or more specialist services (in addition to universal health & education services);
2. The cases should cover a range of ages (as defined in the NICE guidance on maltreatment):
 - Infant (aged under one year) - one case
 - Child (aged under 13 years) - two cases
 - Young person (aged 13 to 17 years) - three cases
3. The cases will include children who are subject to statutory intervention/children in care/children in receipt of short-term breaks. This should include children who are, or have been, 'in need' and/or subject to child protection planning.

2.10 The audit team comprised a core of five senior commissioning and provider leads, representing health and social care services, two of whom were members of the Thematic SCR Panel. A number of managers and practitioners from health, education, social care and the voluntary sector joined the audit team on a case by case basis. The Named Professional for the East London NHS Foundation Trust (Mental Health Services Bedford), who attended for three of the cases, was also a member of the Panel.

2.11 The event was facilitated by the lead reviewer and supported by the BBSCB Business Manager. Discussions were informed by reference to agency case notes. Brief clinical notes for three of the cases were provided by the Named GP, who had sent apologies for non-attendance.

2.12 The audit team agreed some 'ground rules' for the event. These included the need to ensure that there was appropriate and safe challenge. Each case took between one and a half and two and a half hours to review. Where the audit team identified a potential for there to be continuing unmet needs within a case, actions were taken back via the relevant agency lead in line with good practice.

2.13 As per the terms of reference, the focus of the audit was on the provision of services to the child and their family during 2015. However, for a number of the cases, extensive 'background' material was shared. This was helpful in providing context and additional learning.

2.14 The children and families selected for the audit generally had complex needs and provision (see findings). The audit team supported a decision for the Lead Reviewer to scrutinise copies of each child's most recent plan and/or minutes of the most recent multi-

agency meeting. This took place in the week following the audit, with copies of various documents sent by secure e-mail for review.

2.15 Given the volume of data generated, a systematic framework was devised for organising the findings to support analysis and synthesis of the material and onward translation into key issues for learning and improvement for consideration by BBSCB.



2.16 The following section outlines the findings.

3.0 Findings

The children and their families

3.1 The six cases reviewed include disabled children aged from infancy through to 17 years of age. There were three boys and three girls. Five of the children were noted to be white British, and one as being of mixed race. Whilst this sample aimed to be inclusive, it is important to note that Bedford Borough is acknowledged as being one of the most ethnically diverse authorities in the East of England (BBSCB, 2015a).

3.2 All of the children had significant education, health and care needs. These were linked to a range of physical health problems and/or learning difficulties. None of the school-aged children were in mainstream school. The children's needs led to requirements for the provision of specialist equipment and/or adaptations to the family home, as well as the involvement of a number of agencies and professionals.

3.3 The children were of varying birth order within their families and all had siblings; this included the presence of half-siblings and/or step-siblings. In some cases there were children other than the index child with special needs within the family household. Given the links between neglect and developmental delay, it was notable that many of these children had delayed speech.

3.4 Parents and carers of the children included those who were providing kinship foster care. The audit team heard evidence of parents and carers who were providing high quality care for their disabled child, often in very difficult circumstances. These parents and carers were ambitious for their children, and committed to ensuring that, as far as possible, they enjoyed the same childhood experiences of their non-disabled siblings and peers.

3.5 However, there were some parents and carers who had presented with multiple difficulties and disadvantages. These could often be related to their own adverse childhood experiences and/or the additional pressures and challenges of caring for a disabled child (Brandon *et al.*, 2014). In some cases the parents or carers themselves had physical and/or mental health problems and/or learning difficulties. We recorded evidence of complex interpersonal and social problems, including; high-level domestic violence and abuse requiring referral to multi-agency risk assessment conferencing (MARAC), drug and alcohol misuse, social isolation and housing problems.

3.6 The role of fathers/father-figures in both 'single-parent' and other family household configurations was an area that the audit team noted as being generally absent or limited in agency records and narrative. However, it is important to stress that this was not the case for all of the families.

3.7 As requested in the selection criteria, the children and young people were in receipt of a number of services and all were subject to statutory intervention; two were 'children in care'; two were 'children in need' and two were 'subject to child protection plans'.

Historical information

3.8 This thematic SCR aims to provide a window on the quality of the current professional recognition and response to disabled children and young people where neglect may be a feature. Nevertheless, the context of current provision reflects some significant historical information that is important to highlight, not least because it helps to explain the move to compulsory statutory intervention in a number of the cases.

3.9 Similarly to concerns relating to Patrick (and to a certain extent Tomas), the audit team noted a history and background of limited provision, sub-optimal practice, and poor management oversight that had led to significant drift in recognising and responding to evidence of child neglect.

3.10 In some cases this included evidence that the basic hygiene needs of the children were not being met. Again, drift and lack of challenge was a feature here, including by school staff. For example, we heard that:

'[Child's name] was seen to be dirty and unkempt for about a year.'

3.11 The neglect of health care needs was particularly notable. This was seen in the (often multiple) recording of 'missed health appointments' (or no access visits to the home) and the parental failures in compliance or concordance with treatment and therapy for their children. Whilst these omissions in care were recorded by professionals, there is little apparent evidence of challenge, either to the child's parents or to each other.

3.12 Assessments that were undertaken were generally of poor quality and did not adequately inform care planning or promote child-centred outcomes. There was evidence of

a task-oriented, piecemeal and somewhat perfunctory approach to the delivery of care, with little ambition for the children.

3.13 As in Patrick and Tomas's cases, this situation was exacerbated in some of the families by an apparent acceptance of low standards of care, with parents being seen to be 'making do' within the constraints of their (often limited) personal, social and financial resources. Taking a parent-centric stance meant that there were failures in an appreciation of the daily lived experience of the children and in ensuring their best interests.

3.14 This situation was further compounded for several of the children by a noticeable lack of inter-professional dialogue. Had this happened, this may have helped individual practitioners to understand why certain interventions were important to ensure the optimal health and well-being of the child. In turn this would have meant that those practitioners would have been empowered to support the child and family in making difficult care and protection decisions with an appropriate degree of authority.

Care of the children and their families in 2015

3.15 It is pleasing to be able to report that the current situation in Bedford Borough appears to be one of improvement. This mirrors the ambition of the BBSCB and the learning and improvement activities of partner agencies and organisations. However, whilst this thematic SCR of the current care of this small sample of disabled children has identified some substantive findings to support the positive direction of travel, it also finds that there is more to do.

3.16 We begin by highlighting the good practice. Much of this appears to be linked with improved leadership and practice, principally within children's social care services. In particular, there is evidence of both more support, and also more robust challenge; to parents, carers and to front-line practitioners. This is also reflected by the provision of more structured supervision to the continuing care nursing team, who were involved in the care of several of the families.

3.17 For example, in one case it had been recorded that 'parents have been helped to understand the concerns about neglect.' In another, there had been a recent move to statutory child protection proceedings (and legal planning) after evidence of considerable historical drift and longstanding evidence of neglect.

3.18 As the care in these two cases demonstrates, there appears to be better recognition of, and response to, the significance of missed health care appointments and the impact of chaotic parenting and poor home conditions on the child.

3.19 In another case, the 'step-down' from child protection to child in need planning seems to have been well-managed; with the manager supporting practitioners to 'de-escalate professional anxiety' after significant previous concerns. For another child, placement stability was achieved after an unsettling period.

3.20 We found good evidence of 'child-centredness' in the records of one health visitor (HV) who had focused an assessment on the 'daily lived experiences' of the child. This practitioner had also ensured engagement of both parents.

3.21 In this case a chronology had been drawn up to highlight significant events and this was usefully shared with children's social care, who in turn shared their parenting assessment with their health colleague. There was evidence that the case had been discussed at the HV's safeguarding supervision.

3.21 In another case, the lack of involvement of a step-father in the care of his disabled child was being challenged by a social worker in encouraging 'father-son' activities (e.g. watching the local football team play).

3.22 Where children and young people accessed care in the short-stay provision we noted good practice and skills in care staff seeking their views and ensuring their 'voice' in decision-making about them.

3.23 Parents who contributed to the review were also highly complimentary about short-stay provision (including hospice care). Parents and carers develop high levels of technical expertise in managing complex aspects of care alongside the love and support that they provide for their children. Entrusting others to act 'in loco parentis' is understandably a cause for concern for many parents and carers; and it is thus gratifying to share these positive findings.

3.24 In contrast to sub-optimal practice recognised in previous years, the audit found evidence of 'managerial oversight' within children's social care that was demonstrated by the timely sign-off of case planning (on the integrated children's system); as well as by the involvement of managers and practitioners in the case discussions.

3.25 The provision of services to ensure early help to families is rapidly developing in Bedford Borough. Again this is an area that is benefiting from good leadership. Of note here is the provision of services by FACES (family and children's early-help services), who attended the audit for one of the cases and appear to be well integrated with statutory services.

3.26 For the older children in the sample, transition into adulthood and a move to adult services was in progress. The input of educational services is particularly notable. The introduction and use of the *All About Me* passport (Foundation for People with Learning Disabilities, 2012) to help disabled children and young people to contribute to their care planning is another positive to note.

Issues for practice learning and improvement

3.27 Whilst it is pleasing to have been able to find evidence of good practice during 2015, this review has also identified a number of areas where there is more to do. This section highlights the issues for practice learning and improvement. We begin with the importance of the child's voice.

3.28 There was some evidence that the views of children and young people were not always sought, and that they were not always seen alone by professionals, as is good practice. Where children were pre-verbal or non-verbal, or had communication problems, it was difficult to see how their views and/or needs had been incorporated into assessments and formal plans.

3.29 In the cases where child neglect had led to statutory intervention we found examples of sympathy for parents and carers clouding the decision making. However, we also found that in some cases more could have been done to help parents and carers and their disabled children access the range of services and practical and financial support that they are likely to need.

3.30 A parent from the Bedford Borough Parent Carer Forum reported positively on the development of the 'local offer'² but suggested that more could be achieved in raising awareness of the website and in ensuring that all parents and carers were enabled in its use.

3.31 Some parents were also receiving services from specialist agencies. This meant that there were 'adult practitioners' engaged in their care; some of whom had undertaken home visits. The audit team noted scant evidence that these practitioners engaged with the safeguarding and welfare needs of the children within the family; a factor that was reinforced in discussions with a frontline social worker.

3.32 Equally, there was a perceived need for children's practitioners to better understand and enact their safeguarding adult responsibilities. The concept of 'Think Family' (see Social Care Institute for Excellence, 2012) was suggested by the team as being an important omission here.

3.33 We also found a tendency for workers to place an emphasis on 'mothers' when planning for the needs of the children in the family. The voices, roles and also the responsibilities of fathers were under-represented; with the result that they were excluded and that mothers were over-burdened, and perhaps unfairly criticized, when their children's needs were not met.

3.34 In most cases it was challenging for the audit team to grasp and understand the family structure and key events in the life of the disabled child. This was due to an absence of both genograms and/or chronologies in the case notes. The picture needed to be 'built' from agency records before progressing to an understanding of contemporary practice. The audit team agreed that both genograms and chronologies need to be considered as a routine part of high-quality safeguarding and child care practice (see below).

3.35 Although there were good examples of information-sharing, the degree of collaborative multi-agency working to ensure timely and positive outcomes for the children was difficult to judge. We found scant evidence of the systematic gathering, sharing, analysis, synthesis and evaluation of objective indicators of neglect, for example through the use of the Graded Care Profile (Srivastava and Polnay, 1997).

3.36 Whilst acknowledging that children's social care have the responsibility as a statutory lead for safeguarding and child protection, there was an apparent lack of engagement and support from practitioners from other agencies in raising concerns directly with parents and carers. One practitioner from children's social care lamented the tendency for other agencies to pass on information with an expectation that it would be 'dealt with' and then failing to share the responsibility for timely intervention to reduce the risk to children.

3.37 The tensions for all agencies between supporting disabled children and their families, and yet being open to child protection intervention, were clear in the history of some of these

² see <https://sendguide.bedford.gov.uk/>

families. Assessments focused on the disability, which, without the application of a 'child protection lens' meant that issues, such as a failure to gain weight, were not recognised as potential indicators of neglect.

3.38 The impact of a somewhat narrow approach to assessment may have been exacerbated by the evidence of silo-working reported above (3.35). This would have led to missed opportunities for practitioners to contribute their discrete professional knowledge and skills set and thus a more holistic appraisal of the health and care needs of the child.

3.39 This was particularly notable in Children in Need (CIN) planning. We found evidence of children's social care taking a somewhat pragmatic approach that may have excluded the participation (and potentially the contribution) of others in the team around the child and family.

3.40 This approach appears to have limited the opportunities to build a shared understanding of the nature of a disabled child's health, education and care needs and ensuring that these are met in a joined-up, timely and proportionate way.

Issues for organisational learning and improvement

3.41 It was clear from the audit that disabled children and their families may be in receipt of complex packages of care. However, we found that there was some evidence of both overlap and gaps, as well as parental and/or practitioner confusion in terms of agencies' roles and responsibilities.

3.42 Agency representatives (e.g. from social care and education) reported that 'health' is an area that causes particular confusion; and it is apparent that the needs of some of the children require input from a number of different providers, including specialist hospitals. For example, one of the children had five different health organisations involved in their care (and subsequently a plethora of practitioners).

3.43 The role of a Lead Professional (LP) aims to help to co-ordinate care and act as a point of contact for the family and involved practitioners. This is a role that does not yet appear to be fully developed or utilised in Bedford Borough; and the concern here (raised by practitioners and parents themselves) is that by default parents become the LP for their child.

3.44 Given the demographics and geography of Bedford Borough, it was also evident that families move across boundaries (for example into Central Bedfordshire or Luton). Some parents commented that Bedford had poor infrastructure for disabled people, for example a lack of changing facilities and a dearth of provision at public transport facilities. Where families in our sample had moved, there were delays in the transfer of records and difficulties in accessing past records.

3.45 Practitioners and managers reported that there were also delays in receiving minutes of key meetings and copies of plans within the Borough. As noted in the Pan Bedfordshire procedures, the standard for these to be received is within five working days.

3.46 Completed documents sent to the lead reviewer for scrutiny (as per 2.14 above) did not fully reflect the optimism of improvement shared by the managers and practitioners at the audit event. Whilst the child protection planning documentation was generally of a

satisfactory quality, other plans i.e. children in need and looked after children plans, were of poorer quality and not updated as regularly as required.

3.47 There were also gaps in information. This included somewhat limited cross-reference to other plans, including Education and Health Care plans. CIN meeting notes for one child lacked a date, the designation and agency of those attending, and a clear and outcomes-focused action plan for the way forward.

3.48 The documents seen supported an impression gained during the audit (and subsequently reflected in discussions with families) that there is more to be achieved in promoting a culture of joined-up working. More can also be accomplished by ensuring that all agencies embrace their responsibilities in safeguarding and promoting the welfare of children, rather than having an expectation that this role rests solely with children's social care.

4.0 Analysis of issues for practice and policy

4.1 This thematic SCR has a focus on current practice in relation to recognition and response to disabled children and young people where neglect may be a feature. The review builds on the learning from the deaths of Patrick and Tomas. As we have seen, the emergent findings reflect a largely positive direction of travel, but there remains more to achieve.

4.2 This section considers the findings in the context of local and national policies and the evidence base for practice. It is hoped that this learning will not only contribute to further improvements in services for disabled children and their families in Bedford Borough, but also the care and protection of the wider children in need population.

4.3 In Bedford Borough, as is the case nationally, there is evidence that the barriers to identifying child maltreatment (abuse and neglect) in disabled children have prevented recognition and a timely response to children in need of protection.

4.4 It is generally understood that professionals may struggle to identify safeguarding children concerns when working with disabled children. This situation is particularly worrying given the wealth of research and practice evidence that also finds that disabled children are at greater risk of all forms of maltreatment when compared with their peers (Murray and Osborne, 2009; Ofsted, 2012; Miller and Brown, 2014; NSPCC, 2016).

4.5 It is important to share this knowledge to support good practice and policy. The literature (highlighted above) suggests that barriers to identification of maltreatment in disabled children include:

- a loss of focus on the daily lived experiences of the child;
- the presence of communication difficulties (which may include a reliance on parents or carers 'interpreting' for their children');
- children's needs only seen in terms of their disability with broader safeguarding needs not considered;
- denial of a disabled child's sexuality
- consent being judged on chronological as opposed to developmental age;

- professionals interpreting signs and behaviours that are indicative of maltreatment as being linked to the child's disability;
- professionals seeing maltreatment as being attributable to the stress and difficulty of caring for a disabled child;
- parental explanations left unchallenged or unexplored;
- parents or carers not understanding the impact or nature of the child's disability, interpreting behaviours as innate or wilful;
- assessments of parenting capacity failing to recognise the implications of the additional pressures of caring for a disabled child;
- sympathy for parents and carers; including accepting lower standards of care from those who are seen to be 'doing the best' (this is particularly pertinent in Patrick's case, but is also a feature for one of the families in the audit)
- over-identifying with parents or carers and being reluctant to accept that abuse or neglect is taking place, sometimes referred to as 'collusion';
- a culturally embedded negative perception of disability that engenders bullying from other children and a reluctance of the disabled child to engage with support due to embarrassment or fear;
- cultural perceptions of disability as e.g. 'punishment from God';
- social isolation of the parents and child.

4.6 However, whilst the literature is illuminating, it has also been recognised that practitioners have 'little time' to access such learning (Ofsted, 2014). It is thus pleasing to note that BBSCB have already committed to supporting the development of practitioner guidance and a workshop to deliver the key messages and learning from this thematic SCR review.

4.7 Patrick's case reflects the challenges of recognising and responding to neglect of a disabled child. The audit of the six current cases similarly found that the past experiences of some of the children were strikingly similar to those of Patrick. We must therefore echo the sentiments of that review in noting that disabled children 'may not be afforded the level of scrutiny and investigation' and that there may be a 'greater level of acceptance by professionals of unacceptable levels of care for these children' (BBSCB, 2016).

4.8 This is challenging work. As a recent SCR from another authority has noted, exploring parental attitudes to disability and the care afforded to their children can be 'challenging territory' (Kingston Safeguarding Children Board, 2015). Parents' views gathered for this review include a finding that agencies appeared to have a higher level of expectation, and a lower provision of services, where natural (biological) parents were the main carers. As we have already noted, one of the families in the audit, now subject to more robust help and support, had previously been seen to be 'making do'; perhaps reflecting this assumption.

4.9 The solutions to addressing the barriers to good practice in safeguarding disabled children lie in various parts of the 'system'; and it is fair to say that some may rest on a fundamental shift in cultural attitudes to disability. However, many of the issues identified in the literature, national reviews and indeed in Bedford Borough are more readily amenable to changes in practice and policy.

4.10 Of note here is the need to ensure a holistic and child-centred approach to care, that enables a shared understanding with parents, who are then appropriately supported to meet the additional needs of their child (NSPCC, 2016). However, it is also important to recognise that achieving this aim may be more challenging when parents and carers have learning needs themselves (Brandon *et al.*, 2014).

4.11 Communication skills (message given and message heard) need to be finely attuned. The use of language is critical. This was highlighted by parents' contribution to the review in noting that not everyone will have an understanding of everyday terms used by professionals; 'siblings' (brothers and sisters) 'continence aids' (nappies) were given as helpful examples here, but there will be many other professional concepts that may not be readily understood.

4.12 As we have already noted, it is also important to 'hear the voice of the child'. This may be through verbal or non-verbal means, including observations of behaviours such as distress or disruption (with the caveat that these behaviours can be wrongly interpreted as being linked to disability and not maltreatment, e.g. see Murray and Osborne, 2009). As a local health-led³ audit, showcased in the BBSCB Annual Report 2014-2015, suggested:

'If the practitioner has been unable to ascertain the child or young person's voice, they need to record why.'

BBSCB (2015a:41)

4.13 In the same way that professional interpreters are used where there are language barriers, specialist interpreters may be needed to support practitioners' communication with the child. The NSPCC (2016) note that parents may not always be the most appropriate people to interpret for their child. It is also important to create opportunities to see the child alone. This can be difficult within the home setting, especially where the child requires constant supervision and support.

4.14 Parents who contributed to this review told me that parents too need time alone with professionals and that for the reasons given above, this could also be difficult to manoeuvre. As one parent explained, if a child has medical problems requiring constant monitoring, how may parents or carers be given an opportunity to discuss how they are feeling, when this might risk them getting upset or negative in front of their child?

4.15 The need for practitioners to focus on the daily lived experiences of the child and to ensure that all their needs were met in a timely way, was a fundamental finding in the Patrick and Tomas cases. It was also a feature in the background of the current cases that we reviewed. The next section explores the concept of 'drift' in the recognition and response to child neglect.

4.16 The good practice identified in this review has included tackling 'drift' in cases of neglect. This has featured in some of the cases reviewed and the good practice that is seen currently needs to be promoted and sustained.

4.17 A recent national review of the professional recognition and response to child neglect found that a third of the cases that were examined were characterised by 'drift and delay'

³ East London NHS Foundation Trust

that resulted in a failure to protect children from continuing neglect and poor planning for their future care (Ofsted, 2014). Whilst neglect can be linked to failures in the provision for basic needs, such as clean water, food, warmth and clothing, it is also linked to failures in the provision of health care (HM Government, 2015).

4.18 Neglect is the most common form of child maltreatment and the risks to disabled children are higher than in their non-disabled peers (Brandon *et al.*, 2014). As Murray and Osborne (2009) note, disabled children are at greater risk of vulnerability to neglect and other forms of child maltreatment, not least because they are likely to have increased needs relating to physical, sensory, cognitive and communication impairments.

4.19 In reviewing the deaths of Patrick and Tomas, neglect of health needs was particularly apparent. This was also the case in the background and history of some of the cases that were reviewed for this thematic SCR. Some of these unmet needs related to the requirement for significant interventions to improve the well-being of the children, including surgical procedures to support nutrition, posture or mobility.

4.20 It is important to recognise that many of the decisions that parents are asked to make involve not only technical complexity but also have ethical dimensions linked to their children's quality of life and/or palliation. This aspect was brought into sharp focus in the recent SCR published by Kingston Safeguarding Children Board (2015) that was commissioned following the unexpected deaths of three disabled children.

4.21 Here it was recognised that whilst the provision of parental support was crucially important, where there was resistance to interventions that aimed to improve children's health and well-being, including non-compliance with professional advice (e.g. from a physiotherapist) the use of safeguarding and child protection procedures to address ensuring the best interests of children may be required.

4.22 The proactive use of child protection procedures was reported in the Ofsted (2014) thematic review of professional responses to child neglect. This review comments that in cases where there was child protection planning, parents found this helpful in seeing what children needed; a factor reflected in the finding for one family within this current review.

4.23 However, there are known to be recognised tensions, and a different skill set (for social workers in particular) in both supporting families with disabled children and enacting child protection procedures (Murray and Osborne, 2009).

4.24 As Murray and Osborne note, those working in children with disabilities teams (CWD) are likely to have specialist knowledge about the needs and circumstances of the children, skilled communication skills and knowledge of the family's relationships and professional networks. However, as they also suggest, these workers may not have had an opportunity to build expertise in safeguarding children practices and the close relationships with parents can make instigating Children Act 1989 'section 47' (child protection enquiries) challenging.

4.25 Equally, where a child health professional is assessing signs and symptoms in a disabled child, they may fail to make the link with child abuse or neglect as a causative factor. Of course, it is possible for children to be experiencing both a physical manifestation of their disability and maltreatment. Taking a clear and concise history, with input from the

child, parent or carer, and being open to 'thinking the unthinkable', as highlighted in the Daniel Pelka case (Coventry Safeguarding Children Board, 2013), are paramount.

4.26 What is important here is the need to promote 'authoritative practice'; a factor highlighted in another high profile case, that of Peter Connelly (Haringey Local Safeguarding Children Board, 2009). Authoritative practice means practising in a way that reflects urgency, thoroughness and challenge, with a clear focus on the child. It also means embracing a low threshold for concerns and having high expectations of parents and of service provision.

4.27 Authoritative practice can be a difficult concept to grapple with and can raise concerns in those who understand that successful child protection is based on the establishment of trusting and compassionate relationships with families (Munro, 2011). But the two concepts are not mutually exclusive. As Tuck (2013) proposes, trust needs to be established with care, with the professional able to demonstrate 'respectful uncertainty' and 'curiosity' about what is happening within a family.

4.28 The importance of 'professional curiosity' has also recently been highlighted in another local review (Trentham, 2015). Knowledge of the family history, rehearsal of a contact, confidence, and a sense of purpose can all help to underpin authoritative practice.

4.29 Yet, as Brandon *et al.* (2009) suggest, and has been reflected in the local cases, there is a tendency for the 'habituation of professionals' (p.7) to how a child is presenting, and a subsequent failure to question any lack of progress. It is important here to also note, as Brandon and colleagues remind us, that the impact of neglect, in itself, is a cause of developmental delay, as well as long term mental health well-being and social functioning.

4.30 At the time of writing, a significant piece of work on addressing the problem of child neglect is taking place across Bedford Borough, Central Bedfordshire and Luton. The thematic SCR panel have informed me that a new tool, the updated Graded Care Profile (GCP2) is likely to be introduced to help practitioners to work with families in addressing signs of neglect in a more timely and objective manner. Early psychometric testing of GCP2 is promising (Johnson and Cotmore, 2015).

4.31 This section has mentioned children's social workers and health professionals, but we have recognised that there are many others who contribute to the care of disabled children and their families. Whilst a recent multi-agency audit in Bedford Borough found some evidence of strong partnership working (BBSCB, 2015b) this thematic review has found a need for continuing improvement in more 'joined up' working across agencies. This finding was also reflected as a major concern in discussions with parents. This is discussed next.

4.32 The review has found evidence that more needs to be achieved to ensure that safeguarding and child protection is promoted to practitioners as being 'everyone's responsibility' and that this is the case whether they are working primarily with children or with adults in the family. This responsibility must go beyond 'referral' to the need to make a positive and informed contribution to safeguarding at all levels, i.e. early help, child in need and child protection planning.

4.33 The need for children's social care services to be supported in their safeguarding and child protection roles by those working in other agencies and services for children, young people and their families is crucially important. Inter-agency working and co-operation is widely viewed as the bedrock of ensuring children's safety and is a key component of the expectations of statutory guidance (HM Government, 2015).

4.34 The importance of a multi-agency approach to the assessment and planning for children experiencing neglect is reflected in the Ofsted review (2014) as being inclusive of adult mental health and substance misuse services, domestic violence and abuse services and services for adults with learning disabilities. Similarly, Murray and Osborne (2009) report a need for adult workers to be aware of, and to follow, safeguarding children procedures and to recognise the links between adult and child vulnerabilities.

4.35 Whilst the BBSCB Annual Report for 2014-2015 reports on progress in strengthening relationships with adult services, the current review found that there was still more to be achieved in practice in ensuring their contribution to safeguarding children processes.

4.36 In terms of services for children and young people, the role of health and education services are extremely important; these services are universally provided and practitioners working in these services are well-placed to recognise and respond to concerns that children are suffering, or likely to suffer, maltreatment.

4.37 Universal services also have a major role in the development and delivery of Education and Health Care plans and in supporting the transition of disabled young people into adulthood. For school-aged children, the role of the school nurse is cross-cutting and central. For younger children health visiting services are key.

4.38 With recognised pressures on children's social care services (who will only ever be able to respond to cases that meet the threshold for statutory intervention) it is 'increasingly recognised' that there is a need for other child and family practitioners to play a greater role in tackling early signs of neglect (Haynes, 2015).

4.39 Where children are referred to statutory agencies, there is a need for universal services practitioners to continue to be involved, and to contribute their unique sets of skills and knowledge to all stages of the safeguarding and child protection processes.

4.40 This point is reflected in the recently published overview of learning from SCRs involving disabled children. Here it is noted that health professionals often had the best knowledge of the child and family, but saw child protection issues as outside of their remit and purely the concern of children's social care (NSPCC, 2016). This is a really important national finding that was also a feature of the current review.

4.41 Given all the pressures and challenges on families with disabled children, it is also vital that the services that are provided are well co-ordinated. The development of a Lead Professional role has been promoted in children's policy requirements with an aim to reduce the burden on families, whilst ensuring seamless provision to meet additional needs of the children.

4.42 This review found evidence to suggest that the role of the Lead Professional has not as yet reached its potential in Bedford Borough. This may be placing an undue burden on parents and carers.

4.43 Families with disabled children may be overwhelmed by the number of agencies involved in the care of their children, and in some cases are left unsure who to ask for help (NSPCC, 2016). This confusion was found to be a feature in the Kingston SCR, where as many as 60 different professionals were involved with the family (Kingston Safeguarding Children Board, 2015).

4.44 Parents of disabled children in Bedford Borough told me that they were very often left to find out for themselves what support was available. Their role in managing a complex array of professional input and appointments meant that they, by default, became their child's Lead Professional. The support provided by the Bedford Borough Parent Carer Forum was a notable source of assistance, as was networking and friendship with other families with a disabled child, who were often the main source of information on entitlements and practical help.

4.45 Where children's continuing health services were involved, there was some indication of the development of more joined-up pathways for the care of disabled children. However, health provision is complex, and as we noted earlier, some of the children had contact with a number of different providers, not all of whom will have access to information held on different systems.

4.46 The management and sharing of information is an important feature of joint working. The final finding of this review is a need to consider areas for further development in safeguarding practice in Bedford Borough, under a broad heading, as proposed by Laming (2003) that considers the need to be 'doing the basics well'.

4.47 This review has found evidence of good practice. However, there remains more to achieve in ensuring excellence. Successful safeguarding and child protection practice rests, in part, on 'doing the basics well'.

4.48 This final section begins by returning to the title of this review; 'Children First'. Good safeguarding and child protection practice is dependent on the ability to understand the daily lived experiences of the child, to hear their voice, and to keep their needs uppermost.

4.49 This report has referenced the literature that outlines the additional risks of abuse and neglect faced by disabled children, and in doing so has reflected the potential impact of a 'culturally embedded negative perception of disability' (p.15) that may cut across practice, systems and processes.

4.50 The disenfranchisement of children generally, and children with a disability in particular, means that commissioning and provision of services for disabled children may be widely viewed (and thus commissioned) as a 'Cinderella service' (Kennedy, 2010).

4.51 This is important, because although we will move on to discuss 'doing the basics well' at a practice level, any significant deficit in resourcing for the provision of services for children (especially those with additional needs, such as a disability) will have a fundamental impact on the quantity and quality of professional help and support for families.

4.52 However, whilst acknowledging that public services have faced a time of austerity, more resources do not automatically lead to improved provision or practice. This also requires good leadership and a stable, well-trained and supported children and families' workforce.

4.53 It will be important to build on, and sustain, the positive developments already noted in the current provision of care to disabled children and their families where neglect may feature. But as anticipated, the process of SCR may help to focus on areas for further learning and improvement.

4.54 Some of the 'basics' that 'need to be done well' include assessment; the routine use of both genograms (family trees) and chronologies; record keeping; information-sharing; and the quality, management and timely distribution of meeting notes and plans. These issues can be addressed through the BBSCB governance structures, training and quality assurance processes.

4.55 We also found that engagement with fathers/father-figures was an area for improvement. This issue may require a more strategic approach; including a rigorous appraisal of current practice.

4.56 Whilst the professionalism of caring services embraces a 'gender neutral' stance, it was enlightening to hear a social worker actively promoting 'Dad stuff', and similarly to speak to the father of a disabled child who reflected on men's abilities to take responsibility for tasks such as grant applications and finances (in comparison with a maternal hands-on caring role).

4.57 In whichever way the father's role is perceived and enacted, involving fathers does indeed remain a 'gap' in the provision of services to disabled children that requires addressing. The final section of this report outlines the need for this, and other key issues, to be considered by the BBSCB. It also concludes what has been an interesting and hopefully beneficial thematic review into the quality of the current recognition and response to disabled children and young people where neglect may be a feature.

5.0 Issues for consideration by the Bedford Borough Safeguarding Children Board

In Bedford Borough, as is the case nationally, there is evidence that the barriers to identifying child maltreatment (abuse and neglect) in disabled children have prevented recognition and a timely response to children in need of protection.

1. How can the Board gain assurance that an evidence-based understanding of the additional risks to disabled children is embedded in the practice of those providing services to children, young people and their families?
2. How do agencies ensure that frontline practitioners have access to reflective supervision and support, whilst ensuring robust management oversight of case-work?

The good practice identified in this review has included tackling 'drift' in cases of neglect. This has featured in some of the cases reviewed and the good practice that is seen currently needs to be promoted and sustained.

1. How can the Board be confident that the current neglect work-stream will provide a step-change in the timely recognition and response to neglect experienced by disabled children, as well as the child population as a whole?
2. How will these improvements be monitored and evidenced?
3. How have the Board and its partners' embraced authoritative and child-centred practice in working with families who are resistant to service intervention, including the provision of early help?

The review has found evidence that more needs to be achieved to ensure that safeguarding and child protection is promoted to practitioners as being 'everyone's responsibility' and that this is the case whether they are working primarily with children or with adults in the family. This responsibility must go beyond 'referral' to the need to make a positive and informed contribution to safeguarding at all levels, i.e. prevention, early help, child in need and child protection planning.

1. How have the Board and its' partners maintained progress in 'strengthening relationships' with adult services, as mentioned in the Annual Report 2014-2015?
2. How can the Board be assured that agencies and organisations are meeting their statutory duties to safeguard and promote the welfare of children, including the requirement to co-operate with the local authority?
3. Are pressures on the lead agency leading to a focus on task completion and meeting of targets at the expense of ensuring multi-agency collaboration?

This review found evidence to suggest that the role of the Lead Professional has not as yet reached its potential in Bedford Borough. This may be placing an undue burden on parents and carers of disabled children.

1. How can the Board and its' partners support and develop the Lead Professional role to reduce the burden on parents and carers by providing a single-point of contact and ensuring seamless packages of care-provision?
2. How can the Board gain assurance that the 'baton' is held by the most appropriate professional?

This review has found evidence of good practice. However, there remains more to achieve in ensuring excellence. Successful safeguarding and child protection practice rests, in part, on 'doing the basics well'.

1. How can the Board use its strategic influence to improve the provision of services and facilities for disabled children and their families in Bedford Borough?
2. What strategies (beyond a training function) do the Board and its' partners use to build capacity and capability in the workforce?

3. How can the Board and its' partners ensure that fathers/father figures are involved in the care and protection of disabled children?

Glossary of Terms

Child

The legal definition from the Children Act 1989 and statutory guidance applies i.e. someone who has not yet reached their 18th Birthday. For older children the term 'young person' may also be used.

Child Death Reviews

Local Safeguarding Children Boards are responsible for ensuring that a Child Death Overview Panel (CDOP) reviews all child deaths (excluding still-births) within a local authority area. These may be expected or unexpected. Where a death is unexpected (see definition below) a multi-agency Rapid Response process is initiated. This will involve health, police and children's social care. CDOP and Rapid Response processes are outlined in Chapter 5, *Working Together to Safeguard Children* (HM Government, 2015).

Disability

For the purpose of this review an understanding of disability is taken from the Government commissioned non-statutory practice guidance on safeguarding disabled children. This document uses the legal definition provided by the Disability Discrimination Act 2005, noting that a disabled person is someone who has:

'...a physical or mental impairment which has a substantial and long-term adverse effect on his or her ability to carry out normal day-to-day activities.'

(Murray and Osborne, 2009:10)

In keeping with the above guidance, this review also recognises that the key issue to be considered is not how disability is defined, but the impact of any child abuse or neglect on a child's health and development, i.e. 'children first', and how best to safeguard and promote their welfare.

The use of the term 'disabled child' (rather than child with a disability) is reflected in the work of Miller and Brown (2014) who argue that a social model of disability better defines the impact of societal attitudes to disability that result in a range of inequalities, including access to services.

Neglect

This review reflects the definition of neglect as set out in statutory guidance:

'The persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. Neglect may occur during pregnancy as a result of maternal substance abuse. Once a child is born, neglect may involve a parent or carer failing to:

- provide adequate food, clothing and shelter (including exclusion from home or abandonment);
- protect a child from physical and emotional harm or danger;
- ensure adequate supervision (including the use of inadequate care-givers); or

- ensure access to appropriate medical care or treatment.

It may also include neglect of, or unresponsiveness to, a child's basic emotional needs.'

HM Government (2015:93)

Serious Case Review

Serious case reviews (SCR) are situated within the 'Learning and Improvement Framework' set out in Chapter 4, *Working Together to Safeguard Children* (HM Government, 2015). Their purpose is to 'to consolidate good practice' (p.73), to improve services to children and families and to reduce the incidence of deaths or serious harm. The learning and improvement framework recognises different types of review, including audit of practice in one or more agencies.

Significant Harm

The Children Act 1989 defines 'harm' as "ill-treatment or the impairment of health or development". 'Development' means physical, intellectual, emotional, social or behavioural development; 'health' means physical or mental health; and 'ill-treatment' includes sexual abuse and forms of ill-treatment which are not physical. As a result of the Adoption and Children Act 2002, the definition of harm also includes "impairment suffered by hearing or seeing the ill-treatment of another".

Unexpected death of a child

As per statutory guidance, an unexpected death is defined as the death of an infant or child which was not anticipated as a significant possibility for example, 24 hours before the death: or when there was an unexpected collapse or incident leading to or precipitating the events which led to the death (HM Government, 2015:85).

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Appendix One: Terms of Reference



Bedford Borough
Safeguarding Children Board

Terms of Reference

The over-arching purpose of this thematic serious case review (SCR) is to consider the following question:

“What is the quality of the current professional recognition and response to disabled children and young people where neglect maybe a feature”.

This review has been commissioned following the death, in 2014, of Tomas; a child with cerebral palsy, global development delay, epilepsy and feeding difficulties. Similarly to the Child Patrick case, Tomas's death occurred in the context of neglect of a disabled child.

Both cases raise practice questions concerning the:

- Early identification of neglect and disabled children and young people
- Quality of assessments and identification of neglect
- Development of the Lead Professionals' role and responsibilities
- Transition between children and adult services
- Provision of services to disabled children and young people and who takes the Lead role
- Role of education & schools

Review to focus on the here and now and use the two cases identified as a way of giving us a window on the current safeguarding system for disabled children and young people in order that the BBSCB can reassure itself that the current standard of practice is good enough.

Rationale

BBSCB have just finished an SCR (Child Patrick), which has highlighted a number of areas for improvement around the care and support for disabled children. The Patrick SCR learning needs to be considered alongside the learning from the reviews of the other two cases, as well as with contemporary practice. BBSCB need some reassurance that practitioners who work with disabled children are currently recognising neglect early enough and providing an appropriate response and if there are any blocks in the safeguarding system that supports them to identify those blocks and make suggestions as to how to address them.

Period covered by the review

The period from January to December 2015 will be reviewed in detail and prior to this any relevant information to the terms of reference will be included.

Lead reviewer (SCR Author)

Dr Catherine Powell has been commissioned to;

- Chair the SCR Panel meetings
- Undertake conversations with staff, children, young people and families as appropriate
- Write a concise overview report fit for publication
- Present the case to the BBSCB Strategic Board.
- Write a Learning document for dissemination to partner agencies on the learning from the Review
- Facilitate a multi agency briefing event - TBC.

Methodology

The review will be a short concise thematic review that looks at the learning from the three cases to provide a window on the current wider safeguarding system that works with disabled children and explore how disabled children are provided with the best possible support, particularly when neglect may be a feature.

- The Thematic SCR Panel will provide input to the analysis of the findings of the review.
- Background documents evidencing national and local policy and where possible, any existing evaluations of practice in relation to the themes identified disabled children and young people and neglect will inform the review.
- Qualitative (deep-dive) case-file auditing in discussion with partner agencies will take place. Auditors may use the standard Children Services audit tool to carry out themed audits. The Thematic SCR Panel may edit the template by including additional evidence and prompts pertinent to the themes or delete question areas that are not relevant to the review.
- Where possible and appropriate, children, young people and families will be consulted. This may involve the engagement of children, young people and families from a selection of the cases or focus groups with a sample of service users.

Contributors to the Review

- Bedford Borough Council Children and Young People Services
- Bedford Borough Council Education Services
- Bedfordshire Clinical Commissioning Group (CCG)
- South Essex Partnership University NHS Foundation Trust (SEPT)
- East London NHS Foundation Trust (ELFT)
- Royal National Orthopaedic Hospital NHS Trust
- Bedford Hospital NHS Trust
- NHS England
- Children, young people and their families

Thematic SCR Panel

The membership of the SCR Panel are:

- Associate Director - Bedford Borough Council Children & Young People Services

- Designated Nurse - CCG
- Head of Patient Experience and Safeguarding - CCG
- Named Doctor Bedford Hospital NHS Trust
- Head of Service for Safeguarding Children SEPT
- Named Professional for Safeguarding Children - ELFT
- Head Of Vulnerable Pupils & PEP, Vulnerable Pupils - Bedford Borough Council Education Services
- Manager - Child Death Overview Panel
- Business Manager – BBSCB

Areas that the SCR panel may want to explore

What evidence is there of good practice?

Child-centred practice

- How do professionals interpret 'best interests'/paramount principle in practice?
- How do professionals understand children and young people's lives and experiences and how do they ask, 'what must these children's lives be like living in this family'.
- What comes first 'the child' or 'the disability'?
- How do expectations/aspirations for children with a disability compare with those for non-disabled peers?

Neglect

- What is neglect, what does it look/smell like real life examples?
- How do we demonstrate the impact of neglect on children and young people?
- How do we enable professionals to ask sensitive questions around personal hygiene
- What is the protocol for following up children who are 'not brought' (Did not Attend) their health care appointment?
- Do professionals accept the fact that neglect is not only harmful but can also be fatal should be part of their mind set as it would be with other kinds of maltreatment?
- Do professionals and managers recognize how easily the harm that can come from neglect can be minimized, downgraded or allowed to drift?
- How does this thematic review (of neglect and disability) resonate with the wider neglect work-stream?

Parenting support & challenge

- How do we define what is 'parental support' and how and when should professionals challenge when parents/carers decline the support offered to support/improve their parenting/care? How do we get professionals to challenge parents self-reporting? Are there low expectations by professionals of parents, based on experience of disguised or partial compliance and little or no evidence of positive change?
- How do we encourage both adult and children professionals to ask basic questions about family structures (who lives in the family home), language barriers, what and support networks are available to the family?
- How do professionals explore different cultures and their impact on our perceived ideas of parenting?
- Does sympathy for the parents lead to lower expectations of parenting?

- Are professionals reluctant to challenge parents who present as loving but may be failing to cope, for example with the demands of their child's complex health needs or disability?
- Do professionals ask themselves, what does this child mean to the parent and what does the parent mean to the child?

Service provision

- 'What is the 'offer' regarding service provision for children and young people with a disability?' How is this offer delivered, reviewed, updated and monitored?
- Who 'holds' the baton (lead professional?)
- How do adult and children services work together at transition stage?
- When is housing not 'good enough'?
- How can assessments analyse the underlying causes for the neglect?
- Are there any other system based issues/additional factors that have affected the service provision, such as resources, management culture, team dynamics, supervision and support?

Analysis and reporting

- Where possible, the thematic review will link to, and be informed by, other existing quality assurance activities and forums such as parent focus groups, multi-agency learning reviews, children and young people participation groups and local social worker support / focus groups.
- The Lead Reviewer with the assistance of the Thematic SCR Panel will be responsible for producing an analysis report.
- Findings and recommendations will be agreed with, and monitored by, the SIRG on the behalf of the BBSCB.

Findings for the BBSCB

- What do the findings in relation to the care provided for disabled children and young people and neglect tell the BBSCB and member agencies about the strengths and vulnerabilities of wider arrangements to safeguard and promote the wellbeing of children?
- What steps should the BBSCB or member agencies consider taking in order to improve services for disabled vulnerable children and young people?
- Are there any system based issues/blocks that the BBSCB/partnership/single agencies, need to adapt in order that services work more effectively going forward.

Dissemination of Learning

- Communication strategy to be developed
- Learning document to be developed by the Lead Reviewer for dissemination to partner agencies and uploading on to websites and intranets.
- Included in training courses
- Briefing event to be facilitated by the Lead Reviewer and supported by the SCR Panel

Media coverage

Jenny Myers, BBSCB Independent Chair will respond to media enquiries in consultation with other partner agencies there will be a media plan before publication.

Publication

The report will be published in full anonymised and available on the BBSCB website and disseminated to partner agencies.

Other parallel reviews/proceedings/investigations

None identified.

Legal advisor

Legal advisor to be identified via Bedford Borough Council as appropriate.

Liaison with Ofsted

Sally Stocker, BBSCB Business Manager.

SCR timescales

The SCR Thematic Review will be completed within the 6 month timescale.



Bedford Borough
Safeguarding Children Board

Multi Agency Case Audit Template

SECTION 1 (CASE SUMMARY AND KEY INFORMATION)

1a. To be completed by the case holder:

CASE SUMMARY / PEN PICTURE /GENOGRAM

1b KEY INFORMATION

Audit Tracking Number (please circle) Case: 1 2 3 4 5 6	
Azeus Number (Children Services-Social Care):	
Date of audit:	18th/19th January 2016
Name of Auditors and Designation: Organisation	
Team Name (CSC):	
Team Manager (CSC):	
Social Worker:	
Professional network: Health -organisation	Please include details of the service provision, including title and name of professional involved with the child/family. Please include any voluntary sector agencies.

Education			
Others			
Supervisors:		Please state the dates that this case was discussed at supervision and brief outcome.	
Category of case (CAF/ TAC; CiN; CP; LAC; CwD; Care Leaver)			
Age of child/ date of birth:		Ethnicity:	
Gender:		Disability:	[please give full details]
Referral Date (to CSC)		Previous Referrals and Contacts (dates):	[summarise care pre-2015]
Referral Source			
Reason for Referral			
Start/ end date(s) of CiN/ CP/ LAC periods			
Placement Type	This may include 'short-stay' (respite)		

Is the child / young person living out of Borough and if so where?	
Please note gaps in essential information.	
Case-notes/records examined for this audit.	List:

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SECTION 2 (Audit Questions, Summary and Grade) - To be completed by The Audit Team:⁴

AUDIT QUESTIONS

	Criteria	Auditors evaluation (Please refer to Audit Guidance)	Grade
		<p>Please note – Comments should include evidence of what is good, requires improvement and also learning points that are evident in each section. The audit will focus on the care provided in 2015.</p>	
1.	<p>Was effective early help support provided?</p> <p>Has previous historical information been taken in to account?</p> <p>What is the quality of the referral?</p> <p>Has early intervention been appropriately undertaken?</p>		

⁴ Where the audit raises concerns about the well-being and safety of a child, or professional practice, this will be notified to the appropriate agency/head of service for action.

	<p>Has a lead professional been clearly identified?</p> <p>Is there evidence of child/parental/carer engagement/non-engagement with services offered?</p>		
2.	<p>Risk is identified, responded to and reduced in a timely way.</p> <p>Where relevant include evaluation of identification and response to children who experience and/or are at risk of:</p> <ul style="list-style-type: none"> • sexual exploitation • neglect • emotional abuse • sexual abuse • physical abuse • domestic abuse 	<p>This audit will be specifically focusing on the themes of neglect and disability.</p>	
3.	<p>Children, young people and families are appropriately involved</p> <p>Is there evidence of impact of the involvement of children and their families in assessment, planning and intervention?</p> <p>Are the views of significant males effectively gathered? (i.e. those in a parenting/caring role/partners of birth mothers)</p> <p>Are children seen and seen alone and</p>		

	<p>do they benefit from stable and effective relationships?</p> <p>Do children and parents/carers have an equal voice? Does it evidence individual work undertaken, including appropriate direct work?</p> <p>Is this linked to the plan and the reduction of risk?</p> <p>What is the impact of this for children and their families?</p>		
4.	<p>Decision making is effective and timely.</p> <p>Is there evidence of effective and timely management oversight and direction on cases, and clearly recorded rationale for decisions being made?</p> <p>Is case recording clear, comprehensive and reflective of work undertaken and focused on the experience and progress of children and young people?</p>		
5.	<p>Assessments are timely, comprehensive, analytical and of high quality. They lead to appropriately focused help.</p> <p>Are formal tools/frameworks used (e.g. Graded Care Profile)?</p>		

	<p>Do they incorporate historical factors, informed by up to date case chronology?</p> <p>Do they identify risk, needs and protective factors, including parental capacity?</p> <p>How is parental capacity assessed?</p> <p>Is there evidence of sympathy for a parent that detracts professionals from the needs of the child?</p> <p>Is the approach overly parent-focussed (losing sight of the child)?</p> <p>How are the child's health care needs identified?</p> <p>How is concordance/compliance with care and therapy/treatment evaluated?</p> <p>Is there evidence of drift?</p> <p>How are concerns escalated?</p>		
6.	<p>Coordination between agencies is effective</p> <p>Is joint working and information sharing improving the experience and sustaining the progress of children and young people.</p>		

	<p>How is this evidenced?</p> <p>If there is evidence of professional disagreement how is this managed?</p>		
7.	<p>Were previous assessments of a high quality? (E.g. was it timely, comprehensive and analytical? Did it identify risk, needs and protective factors?)</p>		
8.	<p>Consideration and impact of diversity</p> <p>For example, age, disability, ethnicity, faith or belief, gender, identity, language, race and sexual orientation.</p> <p>Use of interpreters and/or specialist communication (e.g. Makaton)</p> <p>Meaning of disability to the child and family, including impact on siblings.</p> <p>Was consideration given to the mental capacity of the young person and how did this impact on decision making?</p>		

9.	<p>Quality of plans.</p> <p>Please state the name/type of plan in place during 2015 (e.g. Early Help/CIN/ CPP/CwD/EHC, health care plan for specific medical conditions/PEP)</p> <p>Are they: up to date and updated, timely, comprehensive, specific with measurable outcomes and dynamic?</p> <p>Are they implemented?</p> <p>Consider length of plan or any themes?</p> <p>Do they show quality of management oversight?</p> <p>Is there evidence of supervision/support of the professionals/workers?</p> <p>Are they influenced by views of children and parents/carers and diversity issues?</p>		
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10.	<p>Permanency is achieved without delay and reflects assessed needs.</p> <p>Are plans for permanency, including adoption, in the best interests of children and young people and achieved without delay? Evaluate the quality of preparation for placement?</p>		
11.	<p>Children and young people participate in and benefit from effective regular reviews</p> <p>Are reviews scrutinised and challenged robustly to ensure that they support children in making good progress?</p> <p>What is the influence and impact of the Independent Reviewing Officer/Child Protection?</p> <p>What is the quality of Looked after Children Health Reviews?</p>		
12.	<p>Quality of placement</p> <p>(at home or looked after) – Are children appropriately placed according to their assessed needs?</p> <p>Evaluate the effectiveness of: matching, stability and maintenance of contact with family/friends support for placements (including adoption</p>		

	<p>support)</p> <p>Are 'short stays' offered (respite) where necessary? How is the impact of these assessed?</p>		
13.	<p>If the placement is out of borough, is there clear evidence of positive action to ensure that the welfare of the child was being promoted?</p> <p>(E.g. clear expectations of the provider, social work engagement with the school, virtual head health providers, promotion of contact where appropriate, identification with Bedford, the IRO's engagement with the child/young person)</p>		
14.	<p>Are young people prepared for independence and are they living in high quality accommodation that meets their needs?</p> <p>Is it safe, permanent and affordable (children at home or looked after)?</p> <p>Is there clarity between children/young people and adult safeguarding professionals and services when managing 16-18 year olds?</p>		

15.	<p>How has the help provided improved outcomes?</p> <p>Are children supported to achieve their full potential? Evaluate impact (including education, physical and mental health, and their emotional well-being).</p> <p>Do children have developed networks within their community and are they safe?</p>		
16.	<p>Has the child / young person had episodes when they were missing?</p> <p>If so was appropriate action taken?</p> <p>Was a return interview undertaken? How was the information from the return interview used to support the child/young person?</p>		
17.	<p>Is the child / young person at risk or previously at risk of CSE?</p> <p>If so was this identified early and was appropriate action taken?</p>		