Torbay Safeguarding Children Partnership

TSCP Multi-Agency Case Audit

Themes of C86 Rapid Review

June 2021

Keeping children safe is everyone's responsibility

Torbay Council Children's Services ■ Devon and Cornwall Police ■ NHS Devon CCG

Contents

1 Introduction

Integral to the new Torbay Safeguarding Children Partnership arrangements[1] is the commitment to improving outcomes for children and young people in line with Working Together 2018.[2] The Partnership has committed to undertaking four Multi Agency Case Audits (MACAs) throughout the year, based on themes directed by the Partnership Executive or that are agreed priorities of the Partnership.

The aim of a MACA is to consider:

- The effectiveness of frontline practice in protecting children and young people
- How well learning from previous MACAs and recent Reviews has been embedded and translated into practice
- The impact of that learning on improving outcomes for children and young people

2 Background

A Rapid Review was undertaken in December 2020, following injuries to a 34-week-old baby who sustained 20% burns to her body and a fractured skull.

The Panel recommended that the case did not meet the criteria for a Child Safeguarding Practice Review, and themes for learning were identified as follows:

- The use of professional curiosity to effectively consider risk to children and young people where multiple adversities are known to be present
- How professionals consider risk and protective factors associated with birth fathers/males in the household
- Consideration of risk to unborn children when primary focus of an assessment is on an older sibling
- Use of the Professional Differences Model to support effective challenge
- Impact of maternal mental ill health on parenting capacity

Although the National Panel and the Partnership Executive agreed with that recommendation, the Executive requested an audit be undertaken to understand the extent to which practice identified within the Rapid Review was reflective across the Partnership.

[1] Safeguarding Children Partnership Arrangements and Child Death Review Arrangements for Torbay, September 2020, Torbay Council

[2] Working Together to Safeguard Children A guide to interagency working to safeguard and promote the welfare of children, updated December 2020, HM Government

3 Methodology

The Terms of Reference for the audit were developed and agreed by the TSCP Business Group. (See Appendix 1) A new audit tool was developed and areas for response agreed in line with the themes identified within the background section above. (See Appendix 2).

This MACA was the first to be undertaken under the new Safeguarding Children Partnership arrangements. Due to Covid restrictions being in place, it was completed via Microsoft Teams.

Due to the requirement to include young children within the audit, it was agreed that the Public Health Nursing Team would identify the children to be audited. It should be acknowledged that the Service Manager & Professional Lead for Public Health Nursing responded very positively to this request and worked to a very tight deadline to identify more than the number of children required which enabled us to include families facing a wide range of issues. The Public Health nursing records provided good oversight of other partners involved in the case, so were able to identify which other agencies should be included in the MACA discussion.

Names of the families to be audited were shared with relevant partners to allow internal review of the cases, with completed submissions being sent to the TSCP in readiness for the main audit which took place on the 19th April 2021.

The audit team consisted of four members of the Quality Assurance Group:

- Chair of the Quality Assurance Group – Chair of the audit
- Education Safeguarding Officer
- Lead Auditor for Children's Services
- Business Manager of the TSCP

Supported all day by:

- Police
- HV Team Leader
- Named Midwife
- CCG Primary Care Safeguarding Team
- CCG DASV Lead

With case specific attendance from:

- Children's Social Care Social Workers and Managers
- Adult Substance Misuse service
- Adult Mental Health service
- Perinatal Mental Health service
- Paediatric Liaison Service

Probation and Housing were also invited to contribute to relevant cases, however the TSCP did not receive any returns from them, nor did they attend.

In total practice relating to ten families was reviewed, with approximately half an hour allocated for discussion per family.

4 Overview of Practice

Theme 1: Professional curiosity effectively considers risk to children and young people where multiple adversities are known within the family

Professional curiosity as an area of practice scrutinised within this audit was found to be inconsistent, and practice varied between good and concerning. Professional curiosity improves multi-agency planning and ensures that children remain the focus of our interventions.

One case provided evidence that a prompt enquiry to children's social care by the midwife, led to immediate identification of vulnerabilities, referral to the targeted help panel which triggered information sharing regarding the risk posed by the father, resulting in threshold being amended from level 3 to level 4 and a single assessment being completed.

In another case, professional curiosity supported effective challenge to parents regarding cannabis use and their false compliance with mental health support. This led to improved quality of assessment and understanding of the children's experiences. All professionals were therefore aware of concerns and there was a shared acknowledgement of assessed risk. Risk captured effectively within CARAs was shared appropriately.

Where professional curiosity prompted unannounced visits to the family home, monitoring of children was more robust and this approach supported informed challenge to parents where concerns were identified.

Some evidence was found that family recordings were being analysed with consideration as to how history increased risk and impacted on current parenting capacity, however this not an embedded multi-agency approach.

Information sharing across the partnership was found to be inconsistent, impacted by changes in allocated workers, restrictions to practice due to Covid and a lack of a shared understanding of the threshold of risk. There was evidence that in one case, children's social care had not shared key information with substance misuse services, leaving significant gaps in care and safety planning that will have elevated risk. Additionally information regarding the step down from a child protection plan to a child in need plan had not been shared with the GP.

The audit identified that whilst midwives do openly ask whether a pregnant woman feels safe at home (where safe to do so), it appears that this question may not be revisited once it has been recorded as being asked. Additionally, it was reflected that conversations that take place during visits may not always be recorded on the midwifery notes. Whilst professionals may well have open and honest discussions with women, this approach relies on self-disclosure. Therefore, how this information is then recorded to inform future contacts and safety planning is not clear.

For one family, there was evidence to suggest that risk from a male returning home from prison may have been known, but how that risk was shared in a timely manner and considered in terms of safety planning for family members is unclear. Due to the fact father was in prison, the

children were stepped down to child in need planning, however there was evidence that the required meetings following step down did not always take place. This created challenge in assessing risk in the multi-agency arena. For these children, risk had changed to include the older sibling alongside the father, however this had not been considered within the safety plan.

Whilst there is evidence that supervision takes place across agencies, there is limited evidence that the supervision process consistently encourages curiosity and effectively challenges practice to consider impact on children.

The audit highlighted that although the ViST form encourages professional curiosity from officers, at times due to the emergency response function, there can be a lack of a holistic approach or cross referencing that considers cumulative risk. Conversely there were examples of good information sharing through tools such as Family Health Needs Assessments, Intra-Agency Communication Forms and CARAs that meant records were updated accordingly, resulting in a robust multi agency plan being understood and implemented.

There was inconsistent evidence of the views of the family being sought by practitioners, where this would enable the family to proactively influence the safety planning where multiple adversities had been identified.

Evidence from the cases audited suggests that whilst family members usually attended initial statutory meetings, this attendance was often not sustained through the reviewing process. Consequently views were not always recorded. This leads to a question of whether families understood the purpose of those meetings, valued the process and indeed, felt valued themselves within it.

Where professionals had developed an open and transparent relationship with parents, audits demonstrated a shared understanding of risk, meaning parents could move from a position of feeling 'done to' to one of being engaged and motivated to make the changes required. These positive relationships supported effective challenge when issues of disguised compliance arose. There was good practice noted where a social worker identified the need to cross reference information that a mother had told her due to disguised compliance being a known concern.

Theme 2: To understand how professionals consider the risk and protective factors associated with birth fathers/significant males

Practice in how professionals engaged with fathers/significant males was varied across the partnership.

There was good evidence of information being shared from risk assessments undertaken by probation, actively informing care and safety planning. In one case both males involved in the family were included in assessments which allowed all aspects of the children's identity and lived experience to be understood. The impact of this was that safety planning was appropriate and therefore more likely to be effective. Where one father was known to be evasive, an approach to engaging him in a meaningful way was adapted so he could be part of the

assessment and supported his understanding of the impact of his behaviour and how that translated into risk.

Further evidence of good practice demonstrated sensitivity and adaptability to approach when a father disclosed difficulty in reading and anxieties as a new father. Alternative methods of communication were established enabling him to be part of the assessment and be clearly aware of the professional concern and risk. In another case children were distressed that they could not receive letters from their father who was in prison. This was followed up to ensure that this key contact could be facilitated.

In contrast to this, there was equally evidence of less proactive practice, with some audits demonstrating limited evidence of the methods used to engage fathers effectively in the assessment process. In one case there was a professional acceptance that it was 'ok' for the male/father to be elsewhere in the household whilst key assessments and discussions regarding risk were being undertaken. Professionals at times appeared reluctant to challenge this absence and therefore this led to a question of how they considered this lack of engagement when considering risk within parenting capacity.

Where fathers/significant males had not engaged in any assessments, the detail within the assessments was based on information held on IT systems rather than direct information from the individual. It was acknowledged that both historical information in relation to risk factors and more up to date information often got lost with changes in social worker. There was evidence that case records for a father linked him with the children, but it was unclear whether he had an opportunity to contribute to the assessment. Additionally, in one case an assessment had been shared with the father who was in prison, but again it was unclear whether he had been given an opportunity to contribute to the assessment.

There was a shared concern that due to restrictions from Covid, fathers and/or significant males were not being seen at some key health appointments, meaning that risk or protective factors in some cases was unassessed.

There was evidence of key partner agencies not having relevant information shared in relation to child protection planning. In one case this resulted in lack of awareness of MARAC concerns, which in addition to the pregnancy and mental health problems would have prompted a different response from the substance misuse services through face to face contact. In this case there was evidence of repeated requests via email to contact the allocated social worker, however it is unclear how the lack of response was challenged or escalated.

In stark contrast to the risk associated with fathers/significant males was a case where there had been information to suggest that the mother had been abusive towards the father, however all risk was focused around the father, who was not spoken to about this.

Theme 3: Understand the extent to which safety planning considers risk to unborn children where the primary focus of an assessment is an older sibling

Once again, findings within this audit demonstrated that although the Unborn Baby protocol was implemented in most cases, there remains an inconsistent approach to safety planning around risk to unborn babies.

Good practice identified showed that in one case where historical risk factors were shared regarding father's previous children, the Unborn Baby Protocol was implemented, and risk assessment and safety planning were undertaken from an informed position. There was evidence of maternity staff being fully aware of the plan upon mother's admission, and discharge planning meetings being held in a timely way involving all relevant professionals. This resulted in a shared understanding of risk between the professionals, parents were given an opportunity to share their views and were fully aware of the professional concerns. Where there was child protection planning in place for an older sibling, evidence suggests that the unborn baby was a joint focus of that plan and risks were considered.

However, less effective practice was identified in another case where there was a delay in the unborn baby panel being held which meant that there was no effective pre-birth planning. Where an unborn baby panel had been held, risks were identified but did not transfer onto the Child Protection Plan, therefore the child was left at risk from mother's alcohol use and poor mental health. One case evidenced a child in need plan that focused completely on the behaviours and needs of the older sibling and did not consider risk factors for the unborn baby. Of significant interest was that in all cases, there was limited evidence of consideration of the potential risk that a new-born baby triggers on its own as an event, in a household that is already experiencing multiple adversities and associated risks.

There was evidence for one family where the relevant professionals were not invited to a strategy meeting, resulting in key information not being considered alongside other presenting concerns. As this was one example within the cases audited, it is unclear whether this is representative. A brief dip sample of recent strategy meetings to check compliance would be recommended to test this.

Theme 4: Understand the extent to which the Professional Differences Policy is used to support effective challenge between professionals, resulting in a positive outcome for children and young people

The findings from this question were of significant interest to the audit team due to previous audits not identifying if the question has not been specifically asked. In those audits there were identified cases where it was felt that the Professional Differences Policy should have been invoked.

For the purposes of this audit the majority of professionals did not believe that the Policy was required for all but one of the cases. It was generally noted that the impact of collaborative working meant that appropriate and effective care planning was in place and there was no need to escalate any professional differences. However, there was one example found where concerns were raised within the audit tool that suggested the policy should have been used.

Where the policy had been implemented, it was used effectively and did not proceed past its first stage, resulting in a positive outcome for the children concerned.

Evidence from the audits suggest that there is not a clear partnership wide understanding of the difference between sharing concerns and raising a formal escalation of professional difference.

Theme 5: Understand the extent to which the impact of maternal mental ill health upon parenting capacity is understood by professionals

This theme once again highlighted a variance in practice around professionals understanding of, and response to maternal mental ill health.

There were areas of good practice where professionals took time to speak with mothers and articulate their concerns, resulting in agreement to referrals into the perinatal mental health team. Additionally, there were examples where professionals had taken time to speak with parents individually and together, in one case having recognised that father's dominance impacted upon mother's ability to engage meaningfully. Further examples demonstrated evidence of the impact of mother's mental health issues being included within the child protection planning, however this was not found to be consistent.

In one case there was evidence that concerns were shared with appropriate professionals including the GP who was in a strong position to support the mother, however she did not access this support. Recognising the vulnerability, the social worker contacted the health visitor to see if she could support the mother to access the support. Further good practice highlighted was the school recognising mother's vulnerabilities and sharing this with the social worker, resulting in further support being provided for the mother and the risk to the children being reduced. One health visitor identified that timely and effective information sharing across the partnership heightened professional's awareness of the need for a more robust exploration of the concerns for mother's mental wellbeing. Support for the mother was included as part of the child protection planning and working in an open way with the mother enabled her to recognise the impact of her traumatic past.

In other cases, where the mother's mental health concerns were discussed at meetings, discussion did not always translate into effective care planning that reflected the risk identified. There were examples where key services such as adult mental health and substance misuse services were not invited to the appropriate meetings. Professionals highlighted this lack of a collaborative risk assessment as detrimental to capturing the large number of unmet needs for the child and its unborn sibling.

At times some of the language used by professionals to describe mother's non engagement with assessments or referrals was concerning. Phrases such as 'unwilling to discuss' or 'couldn't formulate a plan as mum unwilling to engage' suggest an inability to understand the multiple factors that influence individual's ability to access services. In one case it was highlighted that although concerns had been identified in relation to the mother's mental health, she was

'unwilling to discuss them'. The professional went on to highlight 'everyone knows about risks so it's good that we have talked to each other, even if there is no plan in place – we all know about it.' This leaves a question about what professionals proactively and collectively did to consider the safety plan based on the known risks.

Additionally, evidence within the cases audited suggests that following an initial assessment from referral to the perinatal mental health services, mothers did not often meet the threshold for intervention. It is unclear in some cases, where mothers are unable to access this service, or where they do not meet threshold what consistent follow up is undertaken to re-assess risk and what pathways of support can be offered; further how mothers are supported by professionals to access these services when there appears to have been a challenge in doing so.

In some cases there was evidence of no assessments being recorded in relation to mothers mental health, despite there being known risks, nor was there consideration of the impact of the risk on the children or the father. Practice was inconsistent across the partnership in relation to meaningful discussions being undertaken with mothers and fathers too. In one case the social worker identified that this led to a child's pre-birth planning being unsupported by the mother.

Theme 6: Understand the extent to which Covid-19 had an impact on the interventions and engagement by parents on outcomes for children and young people

For some services, such as the police and children's social care, interventions didn't change significantly as a result of Covid restrictions. Anything requiring a face to face contact stayed the same, therefore risk management was maintained. In maternity services mothers were able to access face to face appointments, however the fathers could not attend. Other professionals identified that although Covid was frustrating, and perhaps slowed responses down, it did not prevent interventions taking place. In the cases audited there was evidence that where required, home visits were undertaken using PPE to ensure children were seen and their lived experience assessed.

As per Government guidance there were clear examples within the partnership of Covid Prioritisation Plans allowing robust assessment of risk for continued contact and intervention. For example, children with a child protection plan remained a priority for face to face contacts within public health nursing, and every child allocated within children's social care had a Covid risk assessment undertaken; conversely there were other services where face to face contact with professionals was unavailable. Professionals reported that the multi-agency element of the local response was unclear. It would be recommended that if there was ever a similar situation that required prioritisation planning, there was a system wide overview of service availability provided to staff and the public.

Inevitably, professionals highlighted many concerns due to the impact of Covid restrictions on practice.

In maternity services, although face to face contact continued for mothers, fathers/partners were unable to attend the hospital appointments, leaving a potential unassessed risk due to an inability to identify risk/protective factors and observe the interactions and relationship. Equally

public health nurses highlighted concern that telephone contact with families often only involved the mother, leading to concerns that she could hide or minimise concerns that would ordinarily be visible providing professionals with the opportunity to challenge or explore these with the mother. Restricted visiting in some cases hindered the health visitor's ability to assess attachment, particularly where there were maternal mental health concerns.

Families who were already isolated were further affected by the inability to access baby groups and other resources, and the closure of schools resulted in children becoming 'invisible' to education-based services. Concern was highlighted that remotely held child protection meetings could lead to family members not always having a full understanding of events or feeling able to proactively engage in discussions.

In one case of concern, professionals had limited access to the family whilst they were in temporary accommodation. The mother was heavily pregnant, had a younger child and was placed in a hotel as a temporary measure during Covid. Due to the Covid restrictions the hotel wouldn't allow visitors to see the family. This resulted in social worker and health visitor seeing a heavily pregnant woman and young child in the car park. This contact then led to the family having to move hotels during the pandemic as rules were broken by professionals who did not know they shouldn't be there.

5 REFLECTIONS ON PROCESS

What went well?

Attendance by the practitioners brought a richness to the conversation through their knowledge of the family and therefore really brought the child's lived experience to life.

Acknowledging there was a very tight deadline, school holidays and an Ofsted focused visit, there was a high response rate from partners to required information, allowing robust and holistic discussion on the day.

The use of online Microsoft Teams facilitated the attendance of professionals who were required to attend to represent an individual case. Colleagues who ordinarily may have been time challenged in their attendance due to geographical bases or workloads were therefore able to contribute more effectively.

Recommendations for future audits:

Quality Assurance Group to review process to ensure timeline is agreed with supporting documentation, including summary of case and a genogram available for all panel members

Quality Assurance Group to review the Audit Tool and produce guidance for practitioners to provide clarity of information required, for example, 'exceeding good practice' would require evidence of practice over and above that which policy dictates

Quality Assurance Group to review the wording within the audit tool to ensure practitioners are aware they need to consider impact of practice upon the child, not the service

Quality Assurance Group to agree model of audits going forward, with consideration of a hybrid method to facilitate optimum attendance. This will improve the ability for individual practitioners from all agencies to attend case specific discussion.

Process will be reviewed to ensure that practice in relation to index children only will be audited.

Quality Assurance Group Chair to review number of children to be audited in future MACAs.

Quality Assurance Group to consider involvement of young people and their families in future audits.

6 MULTI AGENCY CASE AUDIT RECOMMENDATIONS

Torbay Council Housing
Torbay Council's Housing department and housing partners to review their policies and procedures regarding duties under Working Together 2018 arrangements to ensure compliance with said duties. Housing policies should promote children's welfare in all circumstances and must not elevate risk or be a barrier to service provision. TSCP to review Housing staff attendance at safeguarding training events and promote attendance if this is not in line with other agencies.

Torbay Safeguarding Children Partnership
TSCP Professional Differences/Escalation policy to be reviewed and updated to ensure it is fit for purpose, synchronises with current multi-agency/TSCP business processes and is used correctly. Updated policy to be re-launched via TSCP information sharing channels. TSCP to manage oversight of the policy where required and feedback any concerns to the Business Group for initial resolution.

Mental Health Services
Ensure the process of risk assessing and supporting mothers with poor mental health who are unable to engage with or access appropriate support services is fit for purpose. Closing an intervention in these circumstances without an adequate risk assessment is likely to increase vulnerability and elevate risk to children and families. This MACA has evidenced concerns in respect of this practice and future dip sampling may need to be considered to ensure compliance with this recommendation.

All Agencies

Ensure that cross-agency practice identifies fathers/adult males within the family home, shares this information with partner agencies, assesses any risk they may pose and/or positivity they may provide and engages them in the care planning process. TSCP to consider learning in this area via the Learning and Development Group and review whether this requires formalising via an update to local safeguarding training.

Children's Social Care

To check compliance with the agreed local attendance protocol for strategy meetings, it is recommended that a dip sample of recent strategy meetings be undertaken. A report summarising the findings should be shared with the Quality Assurance Group, providing assurance in this area.