city & hackney safeguarding children board

Multi-Agency Case Audits

City of London 2018/19

Early Help

Case Summaries

Case 1
CAMHS referred a dual-heritage young person due to concerns over mother's ability to cope with his behaviour. The case was stepped up to Children's Social care (CSC) following a report of common assault on another adult by the child's mother. Following the Child and Family Assessment, it was recommended for the family to be supported by the Early Help Team.

Case 2
Income officer referred a family who were at risk of being evicted. The case was stepped up to CSC when mother took an accidental overdose (no evidence of intention to harm herself).

Case 3
Family were initially supported by the Early Help Team (mother and subject child both have health and learning diagnoses). A Child and Family Assessment was completed on the birth of a new sibling and a short period of statutory support was provided (short breaks). The case was managed under CIN until stepped down to Early Help where mother later withdrew her consent to engage.

Effective Practice

Appropriately applied thresholds for intervention.

Supervision, management oversight and the **recording of decisions/rationale**

Effective Early Help
- Focused lead professional role by the Early Help Worker.
- (Case 1) School relayed that their experience of Early Help was their 'best ever' in comparison to working with other boroughs.
- (Case 3) The early help services offered were deemed to be strong and despite mother's difficulties, the children were held in mind.
- Professionals were tenacious to ensure good outcomes when mother moved her children to nurseries in and out of the City

Multi-Agency Working
- (Case 1) Evidence that whilst partners did not always agree, there was robust discussion and a clear commitment to improve outcomes for the young person. Partners were focused on keeping the young person in school and forthcoming TAC meetings will explore additional support.
- (Case 2) Evidence of professional curiosity by professionals and proactive engagement with mother regarding the possibility of a referral to the police regarding coercion and control.
- (Case 2) Evidence of Victim Support being embedded and co-working with the Social Work Team.
- (Case 2) Evidence that through their respective engagement, mother had a clear understanding of agency roles.
- (Case 3) Although mother is no longer engaging with Early Help services, professionals remain alert to the possibility of future concerns. The Family Involvement Worker in the school maintains ongoing contact with the family and should any issues arise, there is confidence that necessary intervention will be rapid.
- (Case 3) The Health Visitor went above and beyond her duties to attend the GP link meeting which was out of borough.
- The Educational Psychologist is an asset to Early Help services. As there are no secondary schools in City, children are educated out of borough and the application of services are different from school to school. This role helps ensure City children receive the services they need.

Thinking Family

- (Case 1) Regular communication between Probation and Early Help i.e. feedback from parental therapy.
- (Case 2) Professionals developed a strong relationship with the mother which increased her confidence to disclose financial abuse by her partner. She was subsequently empowered by professionals to make positive changes impacting the whole family.
- (Case 2) Evidence of concrete interventions being delivered. In this case, a mother with various debts was supported by a financial advisor. Positive impact as mother is now able to support others in a voluntary role.
- (Case 3) The GP recognised the impact of mother's learning difficulties following a series of missed appointments for the child. The practice changed their approached by calling to remind mother of the appointment and a noticeable improvement was seen.

Capturing the Voice of the Child

- (Case 1) Evidence of the young person always being present at their TAC meetings.
- (Case 1) Evidence of positive and creative ways to engage and capture the interest of the young person. As an example, the Early Help worker has applied for specific funding relating to their interests. The Early Help worker has also considered tutoring outside of school and is aware of the intended career path of the young person.
- (Case 1) The young person is involved in the youth forum which gives young people aged 13 to 19 a voice in reshaping City.
- (Case 2) The child's experiences were captured and recorded in direct work, including observations of their presentation and interaction with mother.

Improving Practice – Key Messages:

Focus on Fathers

Diversity & Racial Heritage

In Case 1, the ethnicity of the child's birth father and the child's understanding of this could have been better explored as part of the multi-agency response to his needs.

- **When working with children, young people and families, do you have a good understanding of the ethnicity, faith, culture, nationality and history of families and how this might impact on a child's wellbeing. Do you include a focus on the background of parents / carers who might not be regularly involved with the child and how this impacts on a child's / young person's identity.**

- **Do you take personal responsibility to be sufficiently informed (seeking advice where appropriate) on the particular culture and/or faith by which a child, young person, adult and their family or carers live their daily lives.**

Working with Perpetrators

Case 2 highlighted that when perpetrators of domestic abuse refuse to engage, there is often a heightened focus on the victim and their role in safeguarding their children. Understanding perpetrator involvement in managing domestic abuse risk and what constitutes safe/unsafe engagement is an important aspect for all safeguarding professionals.

- **Attend the "Engaging Perpetrators of Domestic Violence & Abuse" course. (Sign up to our mailing list to be informed of new training dates across 2019-20!)**

- **Are you aware of local resources for working with perpetrators of Domestic Violence & Abuse? For more information, contact local services in Hackney or Tower Hamlets.**

Unknown Fathers

Case 3 highlighted the difficulties professionals have in identifying the 'unknown' father. In this case, mother did not provide any information about the father despite repeated requests. Professionals demonstrated continued professionally curiosity about the father, maintaining strong communication and continuing to seek any intelligence about him.

- **Do you continue to show professional curiosity when information on family members is not forthcoming?**

Safeguarding First

DNA vs WNB

Cases 1 and 2 highlighted the importance of professionals following up on missed/cancelled appointments. For most children, particularly younger children, they are dependent on their parents or carers bringing them. Not being brought to appointments regularly can be an indicator of neglect.

If children aren't where you expect them to be – you need to rule in or out safeguarding concerns in the first instance.

- **Children or young people are not ordinarily the ones making the choice about attending an appointment. Have you updated your agency narrative / coding to reclassify these events as 'Was Not Brought' (WNB) as opposed to 'Did Not Attend' (DNA)?**

When a pattern of WNB is identified…

- **Attempt to engage parents**
- **Contact the wider partnership to review concerns**
- **Escalate immediately to CSC if there is an identified risk of harm.**

Case Closure

In Case 3, it was highlighted that whilst early help services are consent based, when parents do not engage, professionals should remain tenacious in encouraging involvement where this is considered to be necessary to improve outcomes. Sometimes this can mean holding difficult conversations with families about why you think the case should remain open – despite it not meeting the threshold for statutory involvement.

If cases do close, professionals must remain remain alert to the possibility of future concerns arising and know both how and when to re-refer to CSC.

- **If you would like gain confidence and skill in this area, the CHSCB offers a one-day course on 'Difficult Conversations'. Sign up to our mailing list to be informed of new training dates across 2019-20!**

Case Recording

Recording

Case 2 provided a reminder to all professionals to ensure that relevant decisions/conversations are clearly recorded. The ability to quickly move actions forward is a strength, but all agencies need to ensure they contemporaneously record their work.

- **Do you / your supervisor ensure that you have the time and space to keep on top of your case recording?**

Reviewing Records

Case 2 also highlighted the need for professionals (in this case health) to communicate and also review relevant and available records, from outside of their department. In this case, one health practitioner did not read the full records available and therefore did not have a clear understanding of the issues to inform their own assessment. This was not inhibited by systems issues rather a lack of curiosity to look at other records.

- **If available to you, do you actively consider other assessments/case files from within your organisation before completing an assessment?**