

Leicester LSCB Multi-agency Audit: Disabled Children

Summary Briefing



This summary briefing presents the key findings/recommendations from the audit and is aimed at managers and practitioner working with children and families in Leicester. Please share this briefing with colleagues

Background

- Working Together to Safeguard Children (2015) requires Local safeguarding Children Boards to evaluate multi-agency working through joint audits of case files.
- A multi-agency LSCB audit on Disabled Children was conducted between April-May 2017, to better understand compliance and to seek assurance to the application of the LLR LSCB multi-agency safeguarding procedures; partner agency identification and response to the needs of Disabled Children; identify learning to improve practice in safeguarding children and young people earlier. The audit included accuracy of case details, underpinning this was the 'Voice of the Child' and compliance to procedures.
- The audit report will be presented to the LSCB Performance, Analysis and Assurance Group (PAAG).

Methodology

The audit process, sample and selection of cases, scope and audit tool was discussed and agreed by the LSCB audit group, which has representatives from the following agencies:

Leicester City Council	Leicestershire Partnership Trust (LPT)	Leicestershire Police
Clinical Commissioning Group (CCG)	University Hospitals of Leicester (UHL)	LSCB office

Ten cases were selected for auditing by the LSCB office from a list of cases provided by Children Social Care and the Special Education & Disability Service. The audit focused on multi-agency working and response to meeting the needs of and safeguarding disabled children.

Ten cases were audited by Leicester City Council's – Safeguarding Unit, 5 cases out of 10 audited by Leicestershire Police were within scope, 5 cases were audited by LPT, and in relation to the UHL there was attendance to the hospital in 3 cases (the rest were not known) and no safeguarding concerns were identified. However, one child was identified as having a social worker who was notified of the child's attendance to the hospital as per the hospital's procedures.

Definition of Disability

The rights of disabled children to be treated equally to their non-disabled peers and have fair and equal access to support and services and be protected are enshrined in legislation. Section 17(10) of the Children Act 1989 states that a child shall be taken to be in need if:

- The child is unlikely to achieve or maintain, or to have the opportunity of achieving or maintain, a reasonable standard of health or development without the provision of services by a local authority under Part 111 of the Children Act 1989;*
- The child's health or development is likely to be significantly impaired, or further impaired, without the provision of such services; or*
- The child is disabled.*

According to Article 19 of the UN Convention on the Rights of the Child: *'Children have the right to be protected from being hurt and mistreated, physically or mentally. Governments should ensure that children are properly cared for and protected from violence, abuse and neglect by their parents, or anyone else who looks after them'*. The rights of disabled children are stated under Article 23 *'Children who have any kind of disability have the right to special care and support, as well as rights in the Convention, so that they can live full and independent lives'*

The Disability Discrimination Act 1995 (DDA) defines 'disability' as *'A person has a disability if he or she has a physical or medical impairment that has substantial and long-term adverse effect on his or her ability to carry out normal day to day activities'*. All children and young people should have the opportunity to achieve optimal development according to their circumstances and age and all have a right to be protected.

The Equality Act 2010, encompassed the DDA 1995, and the definition is where you have a *'a physical or mental impairment that has a 'substantial' and 'long term' negative effect on your ability to do normal daily activities'*. *'Substantial' is more than minor or trivial, eg. It takes longer than it usually would to complete a daily task like getting dressed'*; *'long term' means 12 months or more, eg a breathing condition that develops as a result of lung infection'*.

Further Information

[LSCB Website](#)

[LLR LSCB Multi-agency Safeguarding procedures](#)

[LLR LSCB Resolving Disagreement and Escalation of Concerns procedure](#)

<https://www.gov.uk/government/publications/send-code-of-practice-0-to-25>

<https://www.leicester.gov.uk/schools-and-learning/special-educational-needs-sen>

<https://www.gov.uk/government/publications/protecting-disabled-children-thematic-inspection>

<https://schools.leicester.gov.uk/services/special-education-service/statutory-education-health-and-care-ehc-plans/>

[LSCB multiagency audit summaries](#)

Key Findings

The audits identified evidence of expected practice, pockets of good practice as well as areas for improvement, however the overall practice as well as compliance to procedures was variable.

- In relation to case recording there was information missing, not known and religion was not routinely recorded. In some cases, types of disability were inaccurately recorded and Education Health Care Plans (EHCP) were not evident in the Children Social Care children's records. The Children Social Care electronic system did not allow recording of British Sign Language, Makaton or the child's preferred methods of communication. This is important to identify how to engage with the child and inform their assessment and plans.
- There was a lack of evidence of engaging and obtaining the views of the child(ren), and a lack of understanding and use of the child's preferred methods of communication. It is important for practitioners to identify how and who the child prefers to engage/communicate with and endeavour to engage with the child
- All the members of the household were not identified and assessed and the fathers or partners (men in the household) were not engaged with in all the cases, and therefore there was a lack of understanding of who and what support was being offered or provided to the children and carers. In one case there was a lack of information on the records of the child and the child's younger female sibling of whether the latter was in the same household, which was posed a potential risk to her. The audit group recommended that this is checked immediately, to ensure that the female child is not at risk and the correct details are on the child's record.
- In the cases audited, there were two sets of twins (one with a single mother) and in another case there were two disabled children as well as with other children within the household. Having more than one disabled child added pressure on caring responsibilities within the family. This should be recognised by practitioners in order to ensure that the children and their carers are provided with the support they require to reduce any potential safeguarding risks to the children.
- There was a lack of use of research and tools in assessments and in multi-agency meetings. In one case the use of the neglect toolkit, particularly with the parents could have been useful to raise their awareness and understanding of the impact on the children and what is required to support and safeguard the children. The neglect toolkit could also be used to evidence deteriorating condition.
- Limited support provision specifically for older children with autism resulted in difficulties to find suitable short break provision for the twins with the single mother. The mother was exhausted and stressed making it crucial to support her to ensure on-going care for the children. Due to lack of suitable provision, the Disabled Children Service provided support at night and weekends which helped the mother to cope – this was good practice as the service ensured that the children and mother were supported.
- Plans were not SMART and progressed with sufficient urgency in all the cases. In some cases, planning for the future support/services was not evident. Transition planning was not relevant in all the cases and considered to be 'well-thought' out and outlining how future needs would be met only in one case. In two cases, where the children were 14 years of age, there was no evidence that transition planning had started, and in one case where the child is nearly 18 years of age, the outcome of the assessment by the Adult Transition Worker was that the child was unlikely to receive a service. In absence of a post-18 plan for the child the case was escalated by the auditor and the audit group recommended that the child's social worker is asked to contact the Adult Social Care to re-assess this child as a vulnerable adult.
- Education Health Care Plans (EHCP) although completed in some cases were not in the records of all the children who should have had these. The contents of the EHCP were not considered within assessments where the EHCP was mentioned. In the Children In Need, Child Protection or Looked After Children (including Pathway plans) plans there was a lack of reference to the areas covered and decisions reached in the EHCP. According to the auditor, *'this misses an opportunity to ensure that multi-agency planning is well coordinated and addresses all the child's needs'*.
- There was evidence of regular communication and information sharing between agencies and attendance at meetings and reviews, and contribution to the plan, but not in all the cases. In some cases the meetings were poorly recorded and it was unclear who was invited and attended. In the Children Social Care electronic recording system the term 'other professional' is used and if the minutes of the meeting state the name of the individual there is no way of identifying which agencies were represented at the meeting.

Recommendations

Partner agencies ensure that:

1. Within their agencies there is better engagement with disabled children for their views and consideration of their lived experience in informing assessments and plans for the child. This includes identifying and recording of the child's preferred method of communication and considering the practitioner/person who knows the child best and the child prefers to communicate with.
2. Administration of multiagency meetings including Transition and EHCP meetings is improved to ensure that the relevant service/agencies are represented. The practitioners and Chairs of multi-agency meetings ensure that all the plans relating to a child is identified and considered for a co-ordinated approach to planning the outcomes for child.
3. They raise awareness of the [EHCP](#) and [SEND](#) processes within their agencies so that practitioners are aware of what this is and their role in contributing to the EHCP.
4. Case recording, including ethnicity and religion, continues to improve as there is still evidence of not all demographic information being recorded or known by partner agencies.
5. Practitioners within their agencies when working with children should find out who is in the household/family and engage with all members of the household/family, including fathers and partners.
6. Practitioners within their agencies when working with disabled children should find out whether the parents/carers are receiving support and who from, to form a fuller picture of the parents/carers support needs are identified and the implication of these on the child's support needs and safeguarding the child.