Sunderland Safeguarding Children Board

Serious Case Review Report

Family X - Review of multi-agency response to Neglect

Contents

1. Introduction

1.1 In late 2014, a large sibling group, Family X, were removed from their parental care because of a range of concerns for their welfare which indicated they had been exposed to, and were suffering from, chronic neglect.

1.2 The family had been known to multi-agency safeguarding services for over twenty years. The children had been made subject to Child Protection Plans on two occasions for a total of five years. Over the two decades, there are short periods of case closure by Children's Social Care (CSC), but new referrals were activated by partner agencies within weeks or months.

1.3 This case became a trigger for the SSCB to undertake a thematic Serious Case Review (SCR) to consider the effectiveness of the safeguarding systems for children and young people exposed to neglect in Sunderland.

1.4 The Panel considered carefully how to approach this Review in a manner which reached findings and learning about current practice rather than focus too heavily on the retrospective aspects of multi-agency interventions in relation to Family X.

1.5 To this end, it was agreed that the review would initiate and use data collected from a deep dive multi-agency audit into three current children's plans in relation to neglect to identify whether practice had developed since the events that affected Family X and where improvements are still needed.

2. Decision Making Process and Methodology

2.1 The determination as to whether a Serious Case Review was indicated was considered by the Learning & Improvement in Practice Scoping Meeting in April 2015 which made a recommendation that the criteria was met for a serious case review. This was ratified by the Chair of the LSCB in May 2015. There has been a significant delay in undertaking this Review due to the

volume of SCRs and the limited capacity of the SSCB Business Unit to facilitate this.

2.2 The Review commenced in November 2016 some two years after the Family X children became looked after. The Review was overseen by a Review Panel of senior officers from participating agencies and two Independent Reviewers were appointed to support the progress of the Review and write an overview report.

2.3 A detailed chronology in relation to Family X provided a good understanding of how multi-agency practice unfolded, who did what and when. The events in the life of the family and the response of agencies was used as an instructive case scenario from which to reach judgements and consider areas for learning in respect of neglect. The findings from the audited cases then provided a measure as to where practice improvement was evident and where barriers to achieving best outcomes for children are identifiable.

2.4 The Lead Reviewer and SSCB Business Manager met with multi-agency practitioners who were encouraged to think about and share what helped and what got in the way of optimum safeguarding practice. This meeting, which included housing officers, health visitors, Social Workers, a social work team manager, and GP gave the Lead Reviewers the opportunity to explore with the practitioners how the multi-agency response to neglect is currently co-ordinated and the relative strengths and vulnerabilities inherent in the system.

2.5 The Review Panel discussed the need to seek a consultation with the adults with parental responsibility in respect of Family X and the three audited cases. It was determined that the three audited cases were paper audits of practice only and the adults with parental responsibility were not involved in the review.

2.6 Attempts were made to engage with the children's' Mother and both Fathers but they declined to engage. It was decided that due to the delay in

completing the SCR the children would not be contacted as they are settled in permanent placements.

3. Scope and Terms of Reference

3.1 The review did not set out detailed terms of reference, but agreed that the process should lead to an evaluation of the multi-agency work in respect of neglect that could assist the Sunderland Safeguarding Children Board to address areas of vulnerability and maximise areas of strength.

4. Local Context

4.1 An Ofsted Inspection in 2012 concluded that safeguarding arrangements were good but by 2015 Ofsted raised concerns about the effectiveness of the safeguarding systems in Sunderland. The Ofsted reports raised a number of issues which are evident in the approach to Family X. These areas included:

- the timeliness and quality of response to referrals in the Multi-agency Safeguarding Hub (MASH)
- an absence and incompleteness of assessments
- drift in taking legal action to protect children
- instability of allocated workers due to high staff turnover and very high caseloads
- poor quality assurance processes
- the multi-agency arrangements for the oversight of children missing and at risk of sexual exploitation

4.2 Over the last 15 months Ofsted have recognised that steady improvements have been made in Sunderland. This review is intended therefore to establish a benchmark for what now needs to be done collectively to develop effective early help services and better address concerns in relation to neglect.

5. Responses to Family X

5.1 In relation to Family X, this Review has considered the multi-agency intervention between 2013 and 2015. The family had experienced domestic abuse for which the Father of the older children was imprisoned. The first Initial Child Protection Conference took place over twenty years ago when the eldest children were placed on the then Child Protection Register for neglect. The children were registered for a period of over three years, during which time a new male partner moved in to the family home.

5.2 Concerns about the suitability of the physical conditions of the family home are apparent throughout the lives of all the children. The pattern of health interventions shows a generally chaotic approach by the parents, notably with many missed appointments and efforts from professionals seeking to establish engagement from the family.

5.3 A range of repeated concerns are identified as:

- Risk to the family home due to physical conditions
- Criminality of the children
- Soft intelligence about drug dealing
- Chronic non-school attendance
- Sexualised behaviour by one or more children
- High level of accidents suggestive of low level supervision

And, over a long period of time agencies were unable to engage the parents whilst the children were exposed to escalating harm through neglect.

5.4 There is a definite sense that the family had overwhelmed what services could offer and that professional responses were limited to responding to issues as they arose rather than planning targeted interventions.

5.5 The categorisation of Child Protection planning was not always correctly applied. The children remained at on-going risk from the living conditions and chaotic parenting, all of which had a significant impact on their life chances.

The presence of parental alcohol misuse and low level mental health issues were exacerbating factors on the neglect.

5.6 A Child Protection Plan ceased in 2011 after a 20 month period due to 'non-engagement' by the parents. The records indicate an absence of changes to parenting, and continued concerns about missed medical appointments. At this stage there is no evidence to suggest that the parents had made sufficient change to be confident that the children would be safer or better cared for moving forward.

5.7 In the intervening years until the children became looked after, for the most part, they remained subject to multi-agency child in need planning. The pattern of non-engagement continued with action taken to step down to the level of CAF and then case closure which suggests that the threshold application was determined by the response of the parents rather than the assessed needs of the children. In 2013, CSC closed the case due to 'non-engagement' by the parents when it is evident that this had become something of a stuck case.

6. Audit of Multi-Agency Neglect

6.1 The panel selected a small number of current cases for an in-depth audit in order to establish the current position with regard to multi-agency working for children subject to a Child Protection Plan for neglect. The three cases were randomly chosen, but all were children who had been known to agencies for many years. A senior officer from each agency involved in the child's plan completed the audit tool and this information was collated across a range of thematic issues. There was a significant gap in data because there were no audits returned from education or early years. The audit focussed on planning over the previous 2 years.

6.2 The audit revealed variation in the quality of assessment, management oversight and supervision across cases. There is evidence of some good work

but also some that is not of a good enough standard. Significantly, of the three cases, the rationale for making a child subject to the plan in two cases could have been more effective in driving the best response. Whilst all three were subject of a plan for neglect, emotional and sexual abuse were identified as more appropriate categories for two.

6.3 The highlight findings from the audit are summarised as follows:

- That there is a clear application of threshold, each child was appropriately identified as at risk of harm and the Child Protection Plans had been consistent with the child's need and parental engagement
- That each case demonstrated a degree of professional optimism in the light of superficial parental engagement, with small parental gestures being seen as a turning point for change rather than a step on the way
- Perhaps because of the consistent threshold application, inter-agency challenge was not notable except in one case where an Independent Chair Person raised concerns in relation to timescales and potential for drift
- That the Child Protection Plans need to be smarter, to maintain focus and clearly identify what is expected of professionals and the family in relation to agreed goals and objectives
- That the child's voice was not well evidenced and their wishes and feelings were not clear
- That the recordings by practitioners were much improved from that of Family X, and auditors were able understand the child's journey through services
- There were many examples of a positive approach to multi-agency working which demonstrated a strong will to work together

6.4 The headline findings from the audit and what was known to agencies about Family X was shared at the meeting with multi-agency professionals, and practitioners were asked to help the Lead Reviewers to understand locally what helped to respond to neglect and what made successful outcomes less achievable.

7. Analysis of Practice

7.1 Children who are subject to neglect experience both short and long term impacts that have lifelong consequences. The effects of parental neglect on children are cumulative and take several forms; commonly this includes poor physical care, inadequate supervision, inadequate medical treatment and a lack of support to attend school. Neglect can severely affect the way a child's brain works which can lead to depression and other dissociative disorders such as post-traumatic stress disorder or attention deficit hyperactivity disorder. Key findings[1] from SCRs outline that neglect can be life threatening and needs to be treated with as much urgency as any other categories of maltreatment, and that affirmative action is needed to prevent drift.

7.2 Emotional abuse is very often linked to the neglect of a child in that parents who are neglectful for whatever reason are at the very least emotionally unavailable to their children. Poor attachment in childhood can significantly affect the relationships that people have throughout life, including with their own children. The profile of Family X is suggestive of a chaotic form of neglect, and it is in this style of family functioning that professionals are often misled into accepting that emotional needs of children are being met because they are not believed to be setting out to cause deliberate harm.

7.3 Research conducted in 1995[2], drew evidence from six professional groups, health visitors, GP's, paediatricians, police, social workers and teachers. The study used 23 cases of four categories of abuse: physical, sexual, and emotional and neglect. The conclusions drew the following: *' physical and sexual abuse are evidently rated more severely than the other categories by all professionals … as expected, cases of neglect and emotional abuse caused the most dissensus.'* The study demonstrated that neglect can be

[1] Brandon et al (2013) Neglect in Serious Case Reviews UEA

[2] Birchhall and Hallett (1995) Working together in Child Protection

difficult to define because most definitions leave way for personal perceptions of neglect, and that a lack of clarity about what constitutes neglect will have serious implications for professionals who need to be in a position to make clear and consistent judgements to a set of common standards. That clarity needs to be provided through a multi-agency shared approach to neglect, with defined minimum standards, a common descriptive approach supported by an assessment methodology that focusses on the parental capacity for change and the impact on the child.

7.4 The dissensus about what constitutes neglect is evident for Family X when a housing provider made two referrals over a 12 months period leading up to the removal of the children, and then challenged the decision by CSC not to undertake an assessment. As is common in multi-agency working, no one agency had the whole picture of neglect and how this was impacting upon the children, and aware of this fact, the housing provider believed that an assessment was necessary to achieve a complete understanding of the children's day to day lives. The housing provider showed tenacity and sound judgement, which eventually resulted in the children being removed in an emergency because the parents had been unable to engage with a long term programme of change. The whole history of Family X raises a question about how the capacity of parents to make and sustain changes is assessed across the multi-agency partnership as the safeguarding concerns were repeated over sibling generations.

7.5 There are many examples in the history of Family X where the home conditions are described in vague terms which lack a descriptive account, describing the home as 'cluttered' for example does not give a visual meaning, whereas using descriptive words to describe exactly what is observed would provide a more meaningful measure of whether change has occurred or is sustained over a period of time. An absence of detailed recording about the home conditions in which the children were living and how this impacted upon them contributed to long term drift in interventions, compounded by many changes in key professionals. The chronology

prepared for the SCR demonstrates that interventions over many episodes and many years proved to be ineffective, and how the better use of a chronology, both single and multi-agency in casework could have alerted professionals at an earlier point to give greater focus on the poor prospect for change.

7.6 A range of academic sources are available to professionals to help understand and contextualise neglect, such as Howe[3], Howarth. They provide the means for practitioners to categorise the nature of neglect and think about how this may be experienced by children. There is no indication that the children in the family were assessed individually until they became looked after, and it is essential that assessments consider individual children to establish how the effects of neglect are experienced by them uniquely as well as how best to build up any factors that will increase resilience to lifelong impact.

7.7 An assessment of neglect needs to focus on both an understanding of the type of neglect and a detailed appreciation as to how the neglect manifests itself and impacts on the day to day experiences of the child. For Family X, the classification of neglect was generalised, and the records did not show how that neglect was manifested or experienced by the individual children. The records tend to show a series of issues such as poor education attendance, sexualised behaviour, criminality and missed health appointments without any analysis of why this was happening. Drawing on academic knowledge would have helped professionals to think about how the family presented and adapt their approach to focus on the children over repeated attempts to meet their needs through their parents.

[3] David Howe (1995) Child Abuse and Neglect

7.8 A thematic Ofsted report of neglect[4] reached several findings that resonate in Sunderland:

- 50% of assessments did not adequately consider the impact of neglect on the child,
- written plans focused on short term reductions of risk at the expense of sustained long term change,
- non-compliance and disguised compliance are common features in cases where neglect is present,
- to a varying degree drift delayed appropriate action to protect children from further harm.

7.9 In Sunderland there remains a need to focus recommendations from this report and to use the findings of this review to develop an action plan to do so. The multi-agency session with professionals demonstrated that there is no common approach to assessing neglect in Sunderland, and although some believed there had been a plan to introduce the graded care profile, the majority of practitioners were not familiar with this assessment toolkit. The Children and Young People's Plan 2017-2022 the SSCB Business Plan 2017 -2018 and the Improvement Plan for Together for Children – Sunderland all identify neglect as a priority area for development and this report and its recommendations suggests the route forward.

7.10 Analysis of SCRs [5] identifies a number of reasons why neglect poses challenges to professionals, namely because:

- they may become accustomed to the chronic nature of neglect and normalise what they see
- neglect rarely manifests itself in a crisis that demands immediate action
- they need to look beyond individual episodes to see neglect in context

[4] Ofsted (2014) In the Child's Time: Professional Response to Neglect

[5] Pathways to Harm, pathways to protection: a triennial analysis of Serious Case Reviews 2011-2014, Brandon et al

- they may be reluctant to make judgements about parenting when poverty may be a contributory factor and cultural underpinnings are present

All of the above factors can be mitigated against by introducing a multi-agency protocol for neglect. Practitioner's spoke of the difficulties of putting a case of neglect before a Court, with a sense that the burden of proof meant this could only happen once chronic neglect had occurred. The introduction of a clear assessment process using evidence based and properly verified tools, focussing on current and likely long term outcomes for children would withstand the scrutiny of the family proceedings court and give practitioners greater confidence in this regard.

7.11 Practitioners across all agencies were clear that a single interagency tool to support the assessment of neglect is necessary, recognising that the very nature of neglect is often longstanding, entrenched and difficult to evidence in terms of the long term impact or harm. Investigations require three key strands of assessment, the current impact upon the child, the parents' capacity to change and the long term impact on the child if change cannot be achieved. Assessments that cover all three dimensions will help prevent delay or unhelpful or ineffective interventions such as those experienced by the children of Family X.

7.12 Professionals also had no familiar reference point with a model for assessing parental capacity for change, although accepted this to be a critical factor in planning for children where there is risk. We considered how a commonly used change model such as Prochaska and DiClimenti's model of five stages covering motivation, preparation, action and maintenance could be used to predict likelihood of change which would support practitioners who felt that significant harm had to have already occurred before affirmative action would be supported through legal proceedings. The Reviewers formed the impression that adopting a model of assessing capacity for change alongside a tool for assessing neglect would be transformational in assisting multi-agency practitioners to respond to neglect in Sunderland.

7.13 Practitioners also considered that the development of a set of quality standards with regard to neglect would assist practitioners to have confidence in making clear judgements. This would be best developed by local multi-agency practitioners who can consult with colleagues and promote ownership. By way of analogy, practitioners reflected on how practice and confidence improved following the introduction of a Child Sexual Exploitation (CSE) measurement tool in Sunderland which defined risk and supported multi-agency interventions.

7.14 Although multi-agency work around neglect is under-developed, the incidence of neglect as a reason for a Child Protection Plan in Sunderland is significantly higher at 62% than the national average of 46%. This raises questions for the Board, in particular whether all categorisations of neglect are applied appropriately to Child Protection Plans and secondly, how effective assessments and subsequent planning can be without a supporting methodology to effectively grade the quality of care given to a child, and the prospects for sufficient change. The findings of the audit in paragraph 6.3 provide additional context to this question.

7.15 The Child Protection Plan is at the centre of multi-agency working for children at risk of significant harm. To maximise what can be achieved through the plan, it needs to be shared and owned by multi-agency professionals and used as a working tool to engage parents. In respect of Family X, the records show that a plan was in place during Child Protection and Child in Need episodes, although on occasion the absence of an available plan was challenged by agencies.

7.16 The audit revealed across all cases that the child's plan needed improvement to support good outcomes or identify and appropriately respond to escalating risk. Professionals demonstrated a sound understanding of the purpose of the child's plan and the need for it to guide multi-agency working around the child. They commented how often, through audit and management oversight, whilst attention is drawn to plans that need improvement, less focus is given to what

a good plan looks like. Professionals commented that they have received little in the way of training in relation to Child Protection Plans. Notably, the audit completed by the children's conference and review unit revealed that whilst for all three cases, Child Protection Conferences took place in a timely and quorate manner, greater focus should be placed on the sufficiency of the Child Protection Plan at the Conference and the extent to which this addresses the particular strengths and vulnerabilities for the child.

7.17 The Ofsted thematic found that noncompliance and disguised compliance were common features in cases where neglect is present and, to a varying degree, contributed to drift which delayed appropriate action to protect children from further harm. This review has exposed some gaps in the approach to neglect, which if not addressed, will present the circumstances within which such issues can prevail.

7.18 When considering the issues of disguised or non-compliance, the use of chronologies is entirely significant to understanding a child and family's history with services. The audit asked purposeful questions designed to establish how well agencies understood the child and family history and whether this was reflected in current interventions. It was positive that for all cases, a contextual overview as to the reasons why each agency was involved with the child was accessible and that the risks were accurately recorded across the partnership.

7.19 Multi-agency working is intended to provide a seamless approach to safeguarding children across a range of agencies that have responsibility for the welfare of children, however, the day to day reality can be challenging, time consuming and can lead to areas of conflict. Successive inquiries and case reviews have highlighted the importance of working together to share information and taking shared responsibility for the welfare and protection of children. The Practitioners advised the Reviewers that they considered the will to work together in individual cases was strong between community health and CSC, and that this extended to local schools. Currently professional

training about neglect is occurring as a single agency activity although the ability to work together would be enhanced if delivered through a multi-agency programme that encourages and models multi-agency working.

7.20 This Review must comment on the affirmative action taken by the housing provider in their attentiveness to their safeguarding responsibilities and the challenge to CSC when they were not satisfied by the response. It was this challenge that ultimately resulted in the unlocking of information held by different agencies which presented a picture of significant harm once brought together. The Practitioners recognised the key role played by housing providers, particularly in accessing and filtering information from within communities, however, it was noted that housing are not always considered as safeguarding partners and not invited to be part of plans around children. Positively, the housing provider is keen to be as involved as much as possible, and would want practitioners to engage with them across all thresholds of intervention.

7.21 The Practitioner's meetings were attended by the GP for Family X. The GP reflected on how little the practice knew about the on-going agency involvement with the family, as GPs are notified when Child Protection Conferences are convened but not when a Child in Need Plan is in place. The GP present at the Practitioner meeting was an active participant and keen to explore innovative ways of increasing communication between the GP practices and agencies within and outside of health. Other professionals present recognised that GPs are invariably overlooked in information sharing at lower levels of intervention and they too need to be further connected into multi-agency safeguarding activity. In the matter of Family X, the GP had significant information about FX2, which would have assisted the overall understanding of family functioning.

7.22 The Practitioners meeting considered the place for professional challenge, and although this was evident at several points for Family X, the outcome of such was more difficult to establish. Practitioners considered that challenge

took both knowledge and confidence, and commented that a questioning attitude is not easy to maintain unless the organisational culture supports this. Many of the key practitioners had no knowledge of the LSCB professional dispute procedure, and were not aware that they had recourse to this should a difference about a safeguarding matter not be resolved. This procedure provides a useful safety net for practitioners particularly when challenge cuts across organisational hierarchy. Practitioners spoke about the challenge of working in organisations with high staff and management turnover leading to frequent changing ideologies and priorities; this was particularly pertinent for CSC.

7.23 The practitioners believed good quality reflective supervision to be at the heart of supportive management practice. For Family X, the long term outcomes for the children were compromised by repeated patterns of neglect over two decades. Without a willingness and ability by the parents to adapt their parenting approach, then the repeated patterns were predictable. The audit found a degree of professional optimism in all three cases, but also evidence of regular and recorded supervision. Supervisors need to be mindful to offer challenge as well as support to help practitioners to ' think about how they are thinking in order to make their thinking better', in other words, develop and improve upon the skills of critical thinking. The practitioners considered that for some cases, multi-agency professional thinking time would be beneficial, particularly in situations where cases appeared to be stuck.

7.24 The practitioners spoke about the particular challenges to professionals in working with large family groups, both from the perspective of assessing need based on the individuality and impact of neglect for each child, and in addressing an overwhelming amount of parenting issues with the parents. At times, it appeared that the frequency of occurrences compromised the ability of professionals to respond and challenge effectively, and identification of the siblings' needs as individuals is rarely evident. The birth of additional children into an already overwhelmed family did not prompt any updated assessment and the growth in the family did not prompt professionals to think

about how the needs of all the children could be best served by professionals. Professionals spoke of the value of sharing lead professionals across families for core activity with the family but also the need to ensure that no one professional role became overwhelmed by the enormity of the task. This was particularly pertinent to social workers fulfilling statutory functions and seeking to develop a relationship with each child.

7.25 An Ofsted thematic inspection on the Voice of the Child[6] found that children are not seen frequently enough or asked for their views, and that agencies did not interpret their findings well enough to protect the child. The audit report found that although there are systems in place to support the voice of the child at key points of decision, such as MOMO – Mind of My Own application, they are not used consistently. The audit also indicated that direct work with children was limited or unrecorded as an activity. There is indication across partner agencies that professionals understand the need to establish the views of the child, but clearly a more fundamental approach would develop this aspect of practice. What children say about neglect is documented by Action for Children[7]

'sometimes no one believes you. No-one comes to your house to see what's going on so no one can tell from the outside'

'the adults should ask if they think something is wrong not wait for the children to say – it's too hard'

'some kids don't realise they are neglected. It's just their life'.

7.26 The Practitioners meeting discussed the link between neglect and other forms of child abuse. Whilst not all children experience multiple forms of abuse, it is important to recognise that a child impacted by neglect may be particularly

[6] Ofsted (2011) The Voice of the Child: Learning the lessons from Serious Case Reviews

[7] Action for Children, Child Neglect: The Scandal That Never Breaks (2014)

susceptible to other forms of abuse and that professionals need to think critically about this possibility. For Family X there were many indicators of sexualised behaviours and allegations of sexual abuse that should have created a greater alert for professionals. This data on Child Protection Plans in respect of sexual abuse indicates that Sunderland has higher than average percentage of children subject to Child Protection Plans for the category of sexual abuse at 5.5% as opposed to the national average of 4.7%.

7.27 The co-existence of neglect and sexual abuse is an issue that practitioners need to be particularly mindful of, even on the simplest of levels, a neglected child who has low self-worth, compromised cognitive and language development or difficulty in detecting danger will be particularly vulnerable to adults wishing to cultivate a relationship that is presented as 'special'. The additional level of risk applies to both familial sexual abuse and child sexual exploitation. Additionally children living in chaotic households are more likely to be exposed to other intra-familial adults from whom additional risk may be present, and where cognitive distortions may act as justification to abuse a child who lacks care, in the belief that they are providing for an absence of affection.

7.28 This case reminds professionals to be attuned to the possibility of sexual abuse and to ensure that they remain alert to changes in children's behaviours and emotional presentation that could be indicators of further abuse. A report by the Children's Commissioner [8] notes that there is a need to increase the profile of familial sexual abuse amongst professionals, as there has been an over-reliance on children disclosing abuse to commence protective processes. The report advocated a refocus of thinking about sexual abuse so that professionals are attuned to changes in behaviour of children,

[8] Office of the Children's Commissioner (2015) Protecting Children from Harm: A Critical Assessment of Child Sexual Abuse in the Family Network in England and Priorities for Action

their emotional responses and to provide them with opportunities to enable them to talk about their lives.

8 Learning Outcomes

8.1 *Better outcomes would be achievable for children at risk from neglect if multi-agency activity was underpinned by a common assessment tool supported by clearly defined parameters of acceptable standards of care.*

Neglect accounts for largest categorisation of children subject to Child Protection Plans across the county. It is incumbent on partner agencies across the board to use resources to maximum effect, and streamlining assessment processes which support timely and focussed interventions will ensure that children and families receive targeted support in a timely and purposeful way. Whilst surprising to the Reviewers that there was no assessment tool used to assess neglect, it was apparent that this would be welcomed by practitioners at the front line.

8.2 *To avoid drift in achieving positive outcomes for children, it is necessary to give specific focus to parental capacity for change when assessing parents in a safeguarding context.*

The longer a child experiences neglect, the greater the damage and toll on life opportunities. Increasing practitioners understanding of how to assess parental capacity for change will support the delivery of evidence based decision making in a timely way, which can avoid continuation and escalation of harm. Equipping practitioners with the skills to deliver assessments supported by this approach, will give the confidence to withstand challenge from external sources and advocate in children's best interests.

8.3 *For children at risk of harm, a multi-agency approach is best delivered through a Child Protection Plan that adopts SMART planning techniques.*

Whilst the audits found that Child Protection Plans could be smarter, this finding was reinforced by practitioners identifying a need for greater support/training in this aspect of their work. The ability to create good quality

plans from which to address the particular needs of children, and bring clarity of expectation in a timely way to parents and professionals will have a direct correlation to achieving positive outcomes. Currently, single agency training with regard to Child Protection Plans is being rolled out in Children's Social Care, however, this this is not delivered as a multi-agency activity or responsibility.

8.4 *Ensuring the most appropriate categorisation of a Child Protection Plan is significant to the understanding and targeted response to the primary reason for risk*

Categorising the reason for a Child Protection Plan needs very careful considerations, it delivers a critical meaning to the child, parents and professionals about how and where risk is apparent. On a strategic level the collection of such data is also used to understand what is happening in communities for local planning purposes. Although in any plan, wider consideration of risk should be applied beyond one factor, inevitably primary focus will be on the principal reason for risk. To some extent, neglect and emotional abuse are factors that may be present in all categorisations of risk but when applied in their own right, the rationale and likely impact of the abuse on the children needs to be clearly defined. There are obvious pitfalls of practice if risk is misrepresented and there needs to be clear points of quality assurance that reviews the categorisation of risk robustly for example through specific consideration at each core group and child protection conference.

8.5 *When working with chaotic families it is important that professionals remain focussed on the children and their voice, and not be distracted from this by the challenge of working with parents*

Continued crises can be a particular feature of working with families who function through chaos, and in such circumstances there is a danger that professionals spend a great deal of time responding to crises at the expense of planned and targeted work. In such circumstances, it is easy for professionals to mirror the chaos experienced within the family and lose sight

of the need to stick to a plan that focuses on the child. Spending time with a child is a prerequisite to building a relationship of trust, and time on this level is critical to establishing the child's voice and accessing their wishes and feelings.

9. Recommendations

1. In order to improve the effectiveness of multi-agency practice when working with children who experience neglect, support and challenge parents/carers to improve their parenting abilities, develop resilience in children and improve outcomes for these children the Board is:

    - Supporting the Children's Strategic Partnership (CSP) to develop a clear neglect framework, assessment tools, processes and practice models.[9] This will include a set of quality standards to support practitioners when assessing neglect.
    - Work with the CSP to develop and implement a model for assessing capacity to change that can be used across all assessment activity

    This work will be complete by December 2018.

2. To strengthen the multi-agency responsibility to develop and implement robust Child Protection Plans with children and their parents, the Board will review, refresh and implement the SSCB Core Practice Standards for Safeguarding and Promoting the Welfare of Children in Sunderland through Child Protection Conferences and expand it to cover the child protection process. This work will be complete and part of the SSCB procedures by April 2018.

3. The Board to oversee the introduction of quality assurance processes which ensure that children subject to Child Protection Plans remain

[9] (X reference with the SSCB Business Plan 2017-2019 – Theme 4.1 & 4.2 and CYPP 2012- 2022 – Priority 1 & 5)

categorised to the most appropriate source of risk. This work will be complete by April 2018.

4. In order to maintain a focus on the voice of the child in multi and single agency practice around neglect the Board will act on the findings of both the recent SSCB audit on the Voice of the Child and the Section 11 Audit undertaken in 2017 by March 2018.

Appendix 1

Sunderland Safeguarding Children Board (SSCB) impact statement

What have we done, what are we going to do and what difference has it made/will it make?

A new Board structure was implemented from April 2017 with a new permanent Chair in place from May 2017. The new arrangements have strengthened governance arrangements to ensure high support and high challenge across the system, with clearer functions, a new structure, and newly developed and robust approaches to performance management, quality assurance, practice development, and the application of learning from research, evidence and review, as well as evaluating compliance with required standards of practice. The Board has been more effectively supporting (and challenging) the improvement programme for Children's Services and continually evaluating the improvements taking place, the investments being made and the differences these are making to children, young people and vulnerable families as well as supporting and challenging each partner agency's own improvement and development plans.

The SSCB Strategic Plan 2017-2019 and the SSCB Business Plan 2017-2019 have been developed based partially on learning from this SCR. The Board has 3 Service Priorities in these plans which are neglect, vulnerable adolescents and compromised parenting.

In conjunction with the Children's Strategic Partnership (CSP) the Board has implemented an Interim Guide to our Thresholds to support practitioners to better identify when children need early intervention. SSCB training is being delivered to support practitioners to embed the guidance into their practice and early impact evaluation has identified attendees are putting the learning into practice. Through embedding the guidance the Board and the CSP expect multi agency staff to identify a child's needs at an earlier point, increase the number of early help assessments they undertake with families which will lead to a reduction in the number of referrals being made to Children's Social Care, an increase in the number of children who have their needs met through an early help plan and an increase in the number of plans ending with demonstrated improvements for children and young people. This will reduce the need for children to receive statutory intervention and reduce the harm they might have otherwise experienced prior to receiving a service. An audit is planned for November 2017 to evaluate how effectively the interim Guide to Thresholds has been embedded. The training has been evaluated to assess whether it is meeting the needs of the staff and updated based on the findings.

The Board has supported the development of a more robust Early Help Strategy and Neglect Toolkit. Both are now finalised and the Early Help Strategy is launched. The aim of the two documents is to identify children's needs as soon as practicable and reduce the need for social work intervention. This will ensure children have their needs met at the correct time, reducing the likelihood of harm and supporting them to reach their potential. The Neglect Toolkit will be launched in November 2017 alongside multi agency training to support practitioners to use the Toolkit effectively.

A further SSCB audit of neglect practice is planned for March 2018 to understand and assess if practice is improved around identifying and dealing with child neglect.

The Board will continue to audit to understand how effectively learning from the reviews has been embedded access the partnership. An audit undertaken in early 2017 around the Learning from 6 Serious Case Reviews published in September 2016 identified some evidence that learning has been embedded. It has identified further work is needed to embed the learning. A second audit will be completed in November 2017.

Following the SSCB Voice of the Child Audit it has been agreed that all SSCB audits will have a specific focus on how effectively the child's voice, wishes and feelings are evidenced in the assessment and planning for the child. As part of the Board's review and refresh of its workforce development and training offer workshops will be delivered to frontline staff on effective planning which will include a focus on developing plans in partnership with families and with a focus on the child's voice.

The SSCB Scorecard now includes indicators setting out the categories for Child Protection Plans such as, neglect etc. The data will be available in the Quarter 2 2017-2018 report and will be scrutinised by both the Performance and Quality Assurance Programme Board (PQAPB) and the SSCB itself. An initial analysis reported to the PQAPB in September 2017 identified a rise in the number of Child Protection Plans for neglect where domestic abuse is a feature. This information needs to be investigated more fully to ensure that the category is relevant to the likely risk to the child and any work will be overseen by the SSCB.