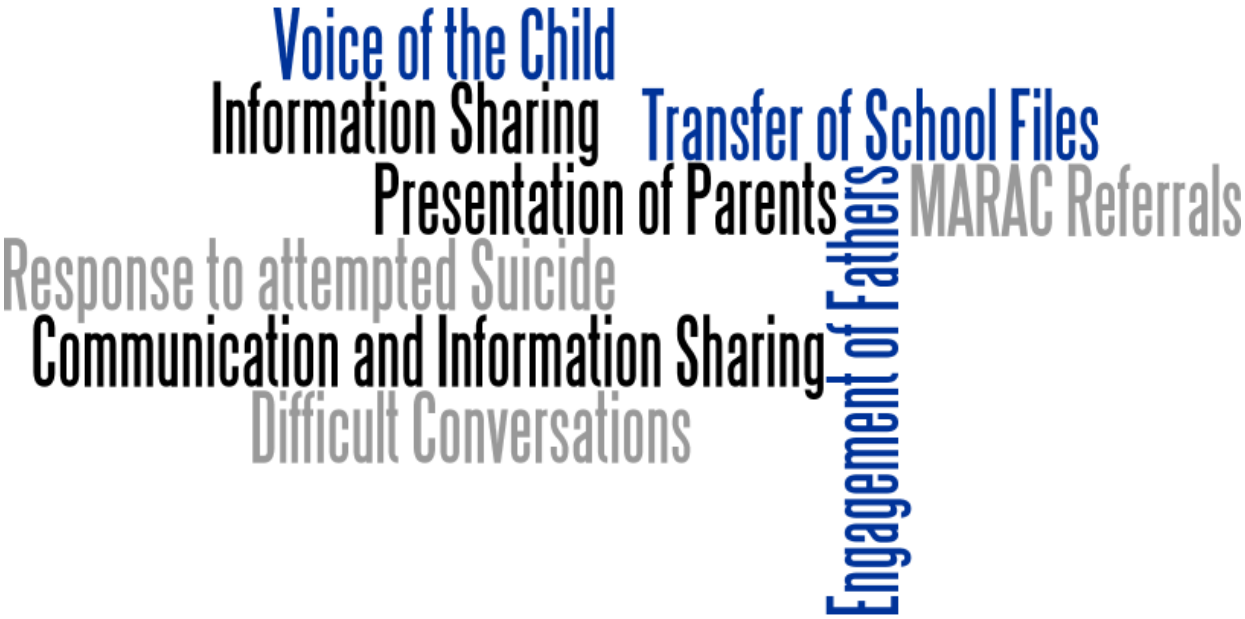
city & hackney safeguarding children board

CHSCB Case Audits Hackney

2017-18: Think Family



Systematic auditing allows the CHSCB to deliver one of the best learning opportunities for front-line workers; directly engaging them in a process that reflects upon, assesses and measures the quality of professional practice. The CHSCB operates a consistent and regular 6 monthly multi-agency case file audit process, which is carried out across the City of London and Hackney.

Brief summary of cases:

- **(Case 1)** Child 1 was referred to CSC due to mother's mental health and their role as a young carer. Concerns were raised around Child 1's complex health needs alongside emotional and behavioural issues.
- **(Case 2)** There were concerns around Child 2's behaviour at school and historic concerns about mother's mental health and non-engagement with services. At the time of the assessment, father was imprisoned.
- **(Case 3)** Due to concerns around a deterioration in mother's mental health, Child 3 and their sibling became subject to CP Plans (later CIN Plans). Child 3 has been arrested for various offending behaviour and was admitted to a mental health facility following a suicide attempt.
- **(Case 4)** Child 4 and sibling are known to CSC following disclosure of domestic abuse between the parents at home.
- **(Case 5)** This case was initially referred for pre-birth assessment due to concerns around mental health and historical substance misuse and domestic violence. Current concerns include mother's anxiety due to issues in temporary accommodation and the volatile relationship between the parents.

Strengths (across the cases):

Voice of the Child

The audits evidenced examples of professionals seeking out and recording the voice of the child including:

- In Case 1, Professionals sought opportunity to speak to Child 1 alone about any concerns they may have. CAMHS tried to engage the subject child at school and used creative methods (i.e. drawing) to directly engage them.
- In Case 2, the school undertook a piece of work *'All about me'* relating to the young person's aspirations and the parts of the curriculum that they enjoy.
- Case 4 evidenced that the social worker got to know the siblings. When asked, the siblings were able to name school representatives who they could speak to if they were upset. This strong relationship enabled the siblings (living amongst domestic abuse) to devise and share the 'house rules' for their parents and discuss emotive subjects (e.g. the death of a family member)

Response to attempted Suicide

Case 3 highlighted an example of a systematic response when a child attempted suicide. Information was shared in a timely manner with good engagement from the Police, Homerton and CAMHS. The young person was visited the next day and informed of their stay in the specialised unit. There was a clear safety plan in place (agreed by the partnership) which considered the wider impact on peers etc.

Communication and Information Sharing

There were examples of good communication, information sharing and multi-agency working throughout the audit, including:

- In Case 1 there was evidence of frequent and timely information sharing between Hackney CFT and an out of borough hospital team.
- In Case 2 there was evidence of partnership working with good representation, communication and discussion by agencies at Education, Health and Care Plan reviews.
- Case 2 also evidenced good partnership work by Young Hackney who attended MAPPA and school meetings and had regular email contact with Probation services.
- In Case 3 there was evidence of good multi-agency working with a clear safety plan in place and consideration of the impact of the attempted suicide on family and friends. Adult Mental Health were aware of children and risk to them was clearly documented on file.

Engagement of Fathers

Cases generally evidenced persistent engagement of parents, alongside professionals specifically trying to engage fathers, as below:

- In Case 1 there was regular attempts to engage father by telephone and current evidence of the Social Work Unit thinking creatively about how to engage him.
- In Case 2 there was evidence of historical non-engagement by a family changing and on release from prison the father being engaged by the professional network, attending meetings and a Non

Violent Resistance (NVR) group session.

- In Case 4, CSC professionals built a good relationship with the family and tried to engage father around the domestic violence issues. Although father cancelled visits and is in denial regarding the concerns, he has attended core groups meetings and vocalised his opinions.
- In Case 5, despite mother's initial reluctance to share information about the father with professionals, there is evidence of him being involved from the second CSC assessment and included in interventions. CAMHS and adult mental health professionals also met with him and recorded his interactions with the child.

Key Messages:

Difficult Conversations

Case 1 highlighted the need for professionals to engage parents in difficult conversations, routine enquiry and challenge. Consideration should also include whether mental health or other issues could be impacting on a parent's reception to difficult conversations.

Are you aware of the CHSCB Group B Training on "Difficult Conversations?"

This course has been designed to help professionals to acquire the skills to manage difficult conversation with families and with colleagues. Find out more HERE!

Information Sharing

Case 1 highlighted the importance of information sharing by GP Practices during the course of Children and Families Service assessments. CSC professionals are reminded that a synopsis of the case should be given when requesting information from all agencies and expectations made clear to ensure a proportionate response.

GPs - Are you familiar with information sharing guidance HERE? If there is a change in your case, do you share within your agency and with appropriate partner agencies?

All professionals - if you have unresolved concerns about the response by health in any case, this can be escalated to the Designated Nurse at City and Hackney CCG.

Do you contact other services to triangulate or test information provided by families?

MARAC Referrals

Case 4 highlighted the need for professionals to access and use the domestic abuse risk assessment tool. Where the threshold is met or their professional judgment indicates the client is high risk, a referral should be made to MARAC. Professionals should risk assess and refer even if the case is open to Hackney CFT.

Are you aware of the domestic abuse risk assessment and referral forms available on the Hackney website? Find them HERE.

Support can be received from the Domestic Abuse Intervention Service. Contactable on: 020 8356 4458 / 4459 dais@hackney.gov.uk.

Presentation of Parents

Case 4 highlighted the need for professionals to consider the wider family when working with an adult client. In one case, professionals noted outbursts of anger and 'verbal aggression' directed from one parent to another. Professionals could have determined the level of risk a child could be exposed to (short and long term) and referred accordingly. If a professional is worried about the presentation of an adult, this must extend to any known children in their contact.

If you witness or are subject to aggression by a parent or carer, do you consider any children they are in contact with? Do you consider the 'lived experience' of the child or young person?

Transfer of School Files

Case 3 highlighted the need to transfer files in a timely manner when a child moves schools (including alternative provision). In this case, the alternative provision felt they did not receive enough information at the start of working with Child 3. Timely information sharing will equip schools with the knowledge to provide appropriate interventions and identify changes/risks at any early stage.

Schools – Do you have a system in place to track transfer of files? Do you monitor and escalate if files are not received in a timely manner?

Are you aware of the CHSCB Escalation Policy? If not, read it HERE – it's important!