

ADDENDUM

WOLVERHAMPTON SAFEGUARDING TOGETHER MULTI-AGENCY SAFEGUARDING HUB AUDIT REPORT

**Sally Wernick March
October 2022**

CONTENTS

Section		Page
1.0	Introduction	3
2.0	Wolverhampton Multi-Agency Safeguarding Hub	3
3.0	Thresholds and Decision Making	4
4.0	Case Findings	5
5.0	Conclusion	8
6.0	Recommendations	9

1.0 Introduction

- 1.1 Following the completion of the Independent Scrutiny Report, it was agreed that a dip sample of children's services cases that had been processed through the Multi Agency Safeguarding Hub (MASH) would be audited to look at whether thresholds were consistently applied. These included whether risk was fully understood, if referrals were properly triaged and whether there was sufficient multi-agency representation and capacity to ensure that partners are working together in a timely way, to ensure the safety of children and improve their well-being.
- 1.2 Twenty cases were available for audit, ten from April to December 2020 and ten from March to July 2022. Each of the cases were selected randomly but included the following outcomes:
- Two cases where no further action was required
 - Three referred to Universal Services
 - Five referred to Early Help
 - Five requiring a Child in Need plan
 - Five escalated to Child Protection
- 1.3 A key focus of the audit was to explore the potential for 'hidden harm' during the COVID-19 pandemic, as well as a focus on exploitation pathways.
- 1.4 In addition, following the publication of the National Review into the murders of Arthur Labinjo-Hughes and Star Robson and the Joint Targeted Area Inspection of Solihull (JTAI), the scope of the audit was extended to apply the findings from these reports. Specifically, whether there was sufficient representation from partners across the spectrum of health providers, that there was access to the right health information, that the timeliness and quality of the initial decision making was good, and that the voice of the child was clearly heard.
- 1.5 As part of the audit, it was agreed that the Independent Scrutineer would spend time in the MASH to meet and talk to partners. To explore how they considered the arrangements and whether they judged they were able to meet children's needs promptly and effectively.

2.0 Wolverhampton Multi-Agency Safeguarding Hub

- 2.1 Since its inception, there have been changes to the working arrangements in the MASH. In June 2021, there was a transition to a 24 hour, working model and changes to the staffing structure. A Service Manager and Operational Team Manager from children's social care take the lead in managing the Hub and are supported by four Senior social workers, two Early Help delivery managers and qualified social care staff. The previous model did not include an operational lead and unqualified Family Support Workers were in place. The current MASH workforce is made up of senior staff from partner agencies such as police, education, health, housing and substance misuse services, they are knowledgeable and in the main there is sufficient capacity to deal effectively with presenting need.
- 2.2 A Threshold Document is in place to inform decision making and all referrals are triaged by a senior social worker and early help manager. The electronic system provides, a clear audit trail and all referrals are assessed according to the level of presenting risk as either Red, Amber or Green. To each of these is an attached

timescale and partners are asked to provide information via the electronic system within a set period. Referrals are regularly monitored by senior social workers throughout the day.

- 2.3 The Operational Manager reviews all the referrals and there is a system of regular audits in place which are completed every quarter. At the time of writing the MASH Managers Board had met and had agreed to review the current audit arrangements, to ensure the right processes are in place during key moments for each child's progression through the MASH.
- 2.4 The Senior Leadership Team receive quantitative MASH data on timeliness and referral numbers through the children's performance dashboard on a monthly basis.

3.0 Thresholds and Decision Making

- 3.1 Overall partners agree and case audits evidenced that thresholds and decision making within the MASH were generally consistent. Some partners reported that on occasion amongst senior social workers, assessment of risk sometimes varied depending who was on duty, whilst the audit did not confirm this, it is recommended that partners should highlight these differences when they are noted.
- 3.2 There is a lot of experience within the partnership and good resources to enable almost all agencies to provide the right information and meet the needs of children, through a range of proportionate interventions. The combined triaging by senior social workers and early help managers, helps to identify those children who might benefit from early help and those who are at greater risk and who should progress to social care and/or strategy discussion.
- 3.3 Neither health partners in the MASH or the police are routinely involved in triaging or asked to provide information on children who are ragged as green and assessed as requiring support from Universal Services or targeted early help. There are occasions when social care staff will request information on a child, where the risks have been assessed as low and where health records would be beneficial. The response to this varies depending on the health practitioner on duty, as health partners are not commissioned to share information at this level and do not always have the capacity to do so.
- 3.4 Health records can be many and varied and for some children may require cross reference to five or six systems, where there are, large families this is time consuming. The outcome of this is that for some children, not all health information is routinely or consistently provided.
- 3.5 For each child that is triaged for assessment, information from some but not all partners is sought and the timescale must be adhered to although this can be open to challenge. Where there is heightened risk, these referrals are rag rated red and progressed within four hours, those that are amber are processed within one working day and cases that are green within three working days.
- 3.6 It is not unusual for triage managers to reassess a referral based on information provided throughout the day, this might mean that a case initially ragged as red may become amber, amber may become green and vice versa. For all colleagues in the MASH not involved in initial triaging, this has on occasions been a cause for concern. Where requests for information on referrals have been

sought and then the referral has subsequently disappeared, because the rating has changed and/or 'timed out', this has led to confusion and some unease about the validity of the assessment as well as the decision making behind it.

- 3.7 Overwhelmingly, partners have raised this as an issue within the MASH. For some there is the worry that low-level neglect and associated risks will be missed without information sharing, for others there is the concern that the threat of timing out is dictating practice, with the fear that the child's voice becomes lost in the process. There is good challenge from agencies within the MASH around thresholds however and how they are applied, and case discussions are held amongst partners where agreement is not present. Some partners in the MASH express frustration at not being involved in the outcomes of referrals and the need as a result to make repeated requests to business support for information to update their own records.
- 3.8 Partners from health have stated that the health portals sometimes indicate that a child has had repeated re-referrals to the MASH, which have been rejected possibly because consent has not been sought and recorded or because information in the MARF has not allowed the case to meet the required threshold. The dip sample from the audit did show one example of these however, operational leads and senior social workers believe that only a significant minority would be impacted. An internal audit of re-referral rates and those where consent may not be present would be helpful to reassure partners that all children presenting to 'front door' services are able to access services when needed.
- 3.9 The value of the MASH is in the good information sharing, but this needs to be proportionate and related to risk. Not all partners are routinely asked to contribute to each assessment, but triage managers are confident that the right agencies are approached, the right decisions are made based on the presenting information, and the right actions are taken to progress to next steps.
- 3.10 In the main this was borne out by the audit as there was evidence that managers were able to identify potential safeguarding concerns and progress referrals that were timely and proportionate.

4.0 Case Findings

- 4.1 Several themes have emerged from the audit, and these have been consistent across all twenty cases.
- 4.2 Thresholds and decision making is in line with the guidance document and evidence from the audit is that this is largely consistent. There is good multi-agency capacity within the MASH, which ensures that referrals are responded to in a timely way and there is evidence of good information sharing.
- 4.3 In most cases consent had been obtained, where consent was not recorded and risks to children identified these were in the main progressed to ensure that there was no delay and children did not remain in a situation where there was unassessed risk.
- 4.4 Children that were referred to universal services were done so appropriately and in line with the risk assessment. In these cases, safe decisions were made for situations that did not require further action from the hub.

- 4.5 For some children where no further action was required within the hub, this meant notification to the teams to which the children were already known. In one example where a referral was made from the hospital in respect of a sixteen-year-old, boy who was well known to services, this was ragged as green on Guardian and referred to the family support worker in the strengthening families' community hub where his case was open.
- 4.6 There then followed a further five referrals to MASH within a six-week period, and continued referrals of repeated self-harm over subsequent months with periods of drift and delay in his case management. These referrals to the MASH did not result in a review of risk either through periods of lockdown or following the easing of restrictions. It was many months before a single assessment was completed and despite numerous referrals where risk was present no strategy discussion was held, or consideration given to a Sec 47 assessment.
- 4.7 It is recommended that where there is a frequency of episodes reported to the MASH and escalating intensity that consideration be given to convening a strategy discussion and progression to a Sec 47 enquiry. In this case too, an Education and Health Care Plan (EHCP) should have been in place to form part of the planning for transition to Adult Services as ongoing support was needed, there was no reference to this in the record.
- 4.8 For those children who have a disability the level of risk was accurately assessed, and they were promptly referred to the specialist team to progress the concerns within a timescale that met the needs of the children. For one family however where there were multiple challenges a whole family assessment could have been suggested to ensure a co-ordinated focused package of support and to highlight where proportionate interventions would be needed.
- 4.9 Good early help services are in place in Wolverhampton, these services though are dependent on consent from parents and a willingness for families to participate. Where there was family discord but where families chose to engage with services good outcomes were recorded and there was evidence that social care staff were able to work effectively with children and their families to identify the support that was most needed.
- 4.10 In eight of the twenty cases domestic abuse was present and in five of the cases there was subsequent re-referral to children's services. All cases were ragged Amber by the MASH and recommended for initial assessment. In each case there was a reluctance from parents to engage in the process this was particularly true of the perpetrators, the majority of whom were not seen or spoken to by social care staff'.
- 4.11 Records did not always clearly indicate if important family members were spoken to. Information included in assessments was not clearly referenced and it was not possible to see if it had been corroborated by extended family and if it was factual. For example, in the case of a small child whose mother was said to be absent from her life there was no evidence that the social worker had made efforts to confirm this or tried to contact her even though she had parental responsibility. Where children were said to spend time with relatives, which was a protective factor it was difficult to see in the case record, evidence to confirm this.
- 4.12 Where there were repeated domestic abuse referrals, outcomes had centred on the abused parent's ability to protect themselves and protect their children despite historical evidence to suggest this was not always possible. A perpetrator

leaving a family home is no guarantee of future safety and should not be relied upon as a key factor in ensuring a child's long-term welfare. There was some evidence that this was viewed as a protective factor by professionals, which unfortunately proved not to be the case.

- 4.13 Where domestic abuse was present, the voice of the child was not clearly visible this was particularly the case with older children who were found difficult to engage by professionals, this meant that the risk posed to the children was not fully explored or understood.
- 4.14 Where there is complexity around domestic abuse this is challenging, and consideration should be given in all cases to working with specialist domestic abuse services to identify risk. Too many of the assessments relied on whether the children had directly observed physical assault and it was this that formed the basis of assessment and intervention. Not all children will show emotional distress or behavioural problems and may not feel able to disclose what may be happening at home either because they are frightened and/or conflicted or because they have been told not to.
- 4.15 Within the audit sample only one of the children presented at risk of Child Sexual Exploitation. This was shortly after the first lockdown and before the exploitation hub was established. It was recommended by the MASH that an exploitation screening tool was completed, and an initial assessment undertaken. The young person was contacted via telephone and video call but did not want to engage with children's social care, she was not seen in person. The file did not show that the assessments were completed, and the case was closed without any further action being taken.
- 4.16 The Exploitation Hub holds a daily briefing each morning and all children for whom there are concerns are discussed and multi-agency-screening tools completed where appropriate. There are excellent working relationships across all agencies including the Multi-Agency Safeguarding hub. An action tracker is in place along with other checks and balances to ensure that children are properly risk assessed, referred for appropriate interventions and not stepped down too early. There is a good level of awareness, strong links with schools and joint work undertaken with local violence reduction partnerships.
- 4.17 Within the case audits where children were older and less willing to engage it was difficult to see effective strategies to overcome this or evidence that professionals were able to overcome reluctance/resistance from parents. In one family the school had made repeated referrals to the MASH concerned about non-attendance of the children and the behaviour of the parent. Several MARFs were rejected because of lack of consent despite the school setting out why they had not been able to obtain this. This did delay the assessment and did not lead to a change in outcome for the children as the case was closed without any further action. At the completion of the audit, they were still not attending school despite their expressed desire to return. The voice of the parent was dominant, resistance was not fully explored, and as a result the focus on the children's needs was missing.
- 4.18 The initial evaluation of risk within the MASH does not always include a cross-reference analysis of siblings to provide a full picture of what daily life is like for a child. An eight-year-old girl referred because of concerns about alleged 'behavioural problems' could not have been properly understood without looking at the experience of her older brother. Concerns had been reported about both

children by a neighbour during lockdown, and the school reported differences about the brother's presentation when going between home and school. Worries about the little girl were reported in a referral to the MASH by an early help counsellor. This case was referred to early help for assessment but did not progress as parents withdrew consent. In this case mothers voice was dominant and the child's voice was not fully heard.

- 4.19 Only one current case was escalated to senior leads during the audit. This was passed to the Community Assessment Team Manager who was undertaking a review.

5.0 Conclusion

- 5.1 Children's safety and well-being is prioritised in the MASH. There is evidence of good leadership from strategic and operational staff who have a clear line of sight to front line practice. There are excellent working relationships amongst partners, with timely and comprehensive information sharing and representation from the right agencies. The workforce is skilled and knowledgeable and there are in the main adequate resources to ensure staff can respond swiftly to meet daily demand. Thresholds are consistently applied, and all referrals are triaged by senior staff who have a good understanding of risk and the presenting needs of the children. Some health staff who are required to check multiple records do not always consider that they are sufficiently resourced within the MASH to do so which, may impact on their ability to provide information as it is needed.
- 5.2 The audit did not identify any delays from health although there was limited information from adult mental health leads who told me they were not always included in initial information gathering. For most children the audit evidenced that the right decisions were made based on the presenting information, and prompt actions taken to ensure each referral was progressed safely.
- 5.3 There is good attendance and information sharing at strategy meetings, which are held promptly and there are regular monthly meetings amongst MASH partners which are well attended, and which support joint learning.
- 5.4 The Exploitation Hub was established in February 2021, and includes partners from statutory and voluntary agencies, with whom there are excellent working relationships including those partners in the MASH. Screening tools and referral mechanisms are in place to identify harm and provide the right partnership response for children at risk.
- 5.5 The Solihull JTAI reported that for a 'significant minority' of children within Solihull the decisions made in the MASH were 'over optimistic and lacked professional curiosity'. This audit did not identify significant gaps within the MASH, although some analysis and context to provide a better idea of the circumstances in which a child is living, should be included in Guardian to encourage critical thinking and reflection, and to avoid repeat referrals and escalation of risk. The initial analysis by Senior social work staff and Early Help managers sets the tone and will influence subsequent information gathering by partners.
- 5.6 The summary of the national review into the murders of Arthur Labinjo-Hughes and Star Hobson set out several key findings. Some of these focus on the importance of critical thinking, engaging reluctant parents, domestic abuse and understanding the daily life of children.
(<https://www.gov.uk/government/publications/national-review-into-the-murders-of->

[arthur-labinjo-hughes-and-star-hobson](#)). Key findings around core issues, practice and practice knowledge, issues around challenge between agencies should all be considered and included in current training for all safeguarding professionals.

- 5.7 Whilst there was evidence of good practice within case management this depended largely on the willingness of parents to engage. Where families showed reluctance there was limited direct work, this was especially true where domestic abuse was present and with older children which, meant that risk was not fully explored. The voices of parents did dominate in some cases and, where consent was withdrawn following initial assessment no further work was undertaken which meant the potential for harm remained.
- 5.8 In October 2022 Wolverhampton Safeguarding Together published on their website the Child Safeguarding Practice Review Panel Paper which set out key findings from reviews where domestic abuse featured. (<https://www.gov.uk/government/publications/multi-agency-safeguarding-and-domestic-abuse-paper>>). The guidance sets out core practice principles which should be included in training for all staff including those within the MASH. Consideration too should be given to including specialist domestic abuse service staff alongside other professionals within the hub.
- 5.9 There were no major differences between those cases audited during the COVID 19 pandemic and the most recent. There are examples of good practice throughout but areas where specific improvements are required particularly in relation to domestic abuse and hard to reach families. There are several recommendations.

6.0 Recommendations

- Where differences are evident within triaging these should be highlighted to managers to support consistency and learning amongst professionals.
- For those cases where consent was not given, and the MARF rejected and, where delays may be present these should be subject of monitoring and review
- Where there are multiple referrals of in respect of a child regardless of whether the case is open, the MASH should consider holding a strategy discussion and progressing to a sec 47 report. Particularly where there is escalating intensity and frequency of episodes.
- Where health records have been sought for children ragged as green numbers should be recorded and monitored to ensure that there is sufficient capacity in the MASH to provide assurance that children are consistently provided with a safe service.
- A record should be kept of those cases where health information was sought and not provided.
- Good early help services are available it is important that these are effectively targeted in the right areas and where consent is subsequently withdrawn this is recorded and reviewed in supervision. For cases that are re-referred this should be considered as part of the initial assessment within the MASH.

- For older children who may be reluctant to engage with Children's services the risks to them should be fully considered and thought given to what opportunities might be available for engagement. These cases should be reviewed before they progress to closure.
- Specific practice improvements related to domestic abuse contained in the national review for Arthur Labinjo Hughes and Star Hobson should be included in the child protection practice framework within Wolverhampton.

Sally Wernick March
October 2022