

Protecting disabled children: thematic inspection

This thematic inspection was commissioned to evaluate the effectiveness of work to protect disabled children and young people at all stages from early support to the identification of and response to child protection concerns. It examined the actions taken to ensure the protection of disabled children and young people, identifying the key factors which promoted effective protection and the barriers to achieving this. It considered how well local authorities and Local Safeguarding Children Boards evaluate the impact of the work done across agencies and by professionals to ensure the effective protection of disabled children and young people. Please note that where references are made to 'disabled child' or 'children' in general terms in this report, this refers to children and young people up to the age of 18 years.

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Piccadilly Gate
Store Street
Manchester
M1 2WD

T: 0300 123 1231
Textphone: 0161 618 8524
E: enquiries@ofsted.gov.uk
W: www.ofsted.gov.uk

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Executive summary

Research on the protection of disabled children indicates that they are more at risk of being abused than non-disabled children.¹ However, they are less likely than other children in need to become the subject of child protection plans.² This suggests either that risks to disabled children are not well identified or that support effectively reduces risks and helps to keep them safe. This thematic inspection found evidence that low level risks were managed effectively through timely multi-agency early support but that children who were in receipt of child in need services too often had child protection needs which went unidentified. When children were made subject to child protection plans good progress was usually made in reducing risks.

Disabled children are usually involved with a wide range of professionals. Most disabled children live with supportive parents who ensure that their needs are met and access services appropriately to help them. Parents spoken to by inspectors whose children received support valued it but some had experienced delays in their children getting the support they needed. Inspectors found that in most cases examined, multi-agency support at an early stage was well coordinated and played a valuable role in tackling any early emerging concerns.

It was evident from the cases examined that staff across a very wide range of agencies identified child protection concerns and referred these appropriately to children's social care. Inspectors found that when child protection concerns were clear they were investigated promptly and effective action was taken to ensure children were safe. However where concerns were less clearly defined the response was not always the right one. In some cases examined by inspectors' decisions and assessments were not consistently well informed by previous concerns. As a result some cases were closed too early before risks were fully assessed.

Disabled children are more dependent than other children on their parents and carers for their day-to-day personal care; for helping them access services that they need to ensure that their health needs are met; and for ensuring that they are living in a safe environment. The impact of neglect on disabled children is therefore significant. This is not always recognised in time. In many of the child protection cases examined by inspectors, where neglect was the key risk, children had previously received support as children in need for a long time. Despite the lack of improvement for the child there were delays in recognising that the levels of neglect had met the threshold for child protection. In many of these cases the impact of poor parenting on the child was not clearly seen and the focus on the child was lost.

¹ PM Sullivan and JF Knutson, 'Maltreatment and disabilities: a population-based epidemiological study', *Child abuse and neglect*, 24(10), 2000, pp 1257–1273; <http://childabusemd.com/disabilities/disabilities-resources.shtml>.

² Children in Need census as at 31 March 2011, Department of Education, 2011; www.education.gov.uk/rsgateway/DB/STR/d001025/index.shtml.

In some local authorities children in need plans were not clear, assessments were out of date and cases were not reviewed regularly. This contributed to the lack of robust monitoring and delays in identifying ongoing concerns in children in need cases. In the majority of cases where the children were made subject to child protection plans good progress was made to improve the quality of parenting or reduce the risks. Some of the parents with whom inspectors met said that having their child on a child protection plan helped them to understand and accept the seriousness of what was happening.

Inspectors found a mixed picture regarding how well the views, wishes and feelings of disabled children were captured. In cases where their views were well represented staff knew them well and took time and care to ascertain their views, using observation and their knowledge of the child to interpret behaviour where children had very complex needs. However, children's views were not always evident, and even in cases where it was clear that they had no specific communication difficulties they were not always asked about issues of concern or risk. Advocacy services were rarely used.

The local authorities visited gathered information about disabled children to help them plan services. However most did not use information well to analyse how effectively they were protected. Very few Local Safeguarding Children Boards (LSCBs) scrutinised the quality of work across agencies to ensure that thresholds for child protection for disabled children were understood and rigorously applied. Because quality assurance and case file auditing of work with disabled children were not well established, most LSCBs were not in a position to evaluate the quality of practice with them and the impact of this on ensuring their protection.

Key findings

- Most disabled children were recorded to be living with parents or carers who were well motivated to provide good care for them. In almost all cases they recognised or accepted that they and their children needed additional support and were keen to take up available services. Parents found the support provided helpful. Effective multi-agency support was provided at an early stage in the cases examined by inspectors. When early concerns for children's welfare or emerging risks arose, in most cases these were tackled well, ensuring that their well-being did not suffer and that their safety was not compromised.
- A wide range of professionals and staff made timely referrals when they had concerns about disabled children. However contacts with, and referrals to, children's social care were not routinely analysed to consider if the proportion of referrals relating to disabled children reflected the proportion of disabled children within the local area.
- Children in need work was not always well coordinated; many plans were not detailed or focused on outcomes. In a small number of cases children had no plans or reviews were not held. In other cases reviews did not always include other professionals working with the children. This lack of rigour in the

management of child in need work increased the likelihood of child protection concerns not being identified early enough.

- When child protection concerns were clear they were investigated promptly and steps were taken to ensure that children at immediate risk were safe. However when concerns were less clear-cut, and particularly when the concerns related to neglect, there were delays in identifying when thresholds for child protection were reached. Assessments did not consistently identify and analyse key risk factors, including previous concerns. This led to delays in some disabled children getting the right level of support and intervention needed to protect them.
- When these children did become subject to child protection plans there was a marked improvement in their outcomes. Effective action was taken to reduce the risks to them and in the majority of cases they made good progress. Parents understood why their children were subject to plans and most accepted the reasons for the concerns.
- Many child protection plans were not sufficiently focused on outcomes, making it difficult to hold agencies and parents to account and to measure progress. In a very small number of very complex child protection cases examined by inspectors there was no robust and timely action to respond to increasing or ongoing risks.
- Child protection enquiries were usually carried out by suitably trained, experienced social workers with good experience of working with disabled children. Although the majority of staff working with disabled children had attended specialist training in safeguarding disabled children, this still left a significant minority without such training. Specialist training is not available in all local authorities.
- A small number of children supported as children in need had previously been the subject of child protection plans. These cases were managed effectively. Social workers showed good understanding of the risks and the need for constant vigilance in the light of the previous, often very substantial, child protection concerns.
- The extent to which the views, wishes and feelings of disabled children were captured and recorded varied. In many cases professionals knew children well and were skilled in communicating with them and in using observation of behaviour to assess how they were feeling. However, children were not always spoken to directly about the concerns for their welfare even when they could communicate well. Advocacy was usually not considered and was rarely used.
- Most LSCBs and local authorities were not in a position to assess the quality of work to protect disabled children. Systems were not well established to evaluate and report on the quality and impact of work to ensure that child protection concerns for disabled children were recognised and responded to effectively.

Recommendations

Local authorities and Local Safeguarding Children Boards should:

- ensure that thresholds for child protection are well understood and rigorously applied at every stage in work with disabled children
- establish robust quality assurance case file audits and management information systems to assess and evaluate the quality and impact of work with disabled children
- ensure that findings are reported to LSCBs and local authorities' senior management to enable them to evaluate whether concerns regarding disabled children are identified and responded to effectively
- ensure that local authority designated officers (LADOs), who are responsible for arrangements for managing allegations against staff, carers or volunteers, identify, analyse and report on allegations relating to disabled children to ensure that concerns regarding disabled children are appropriately referred. They should take prompt action to explore the reasons for either under- or over-reporting and track outcomes for disabled children compared with their peers.

Local authorities should:

- ensure that all decisions and assessments relating to disabled children are well informed by previous history and are based on up-to-date multi-agency assessments which include a thorough analysis of risks and needs
- ensure that careful consideration is always given to how best to obtain children's views, taking the children's disabilities into account, and that wherever possible children's feelings are sought about the identified concerns and risks
- ensure that all disabled children receiving children in need services or subject to child protection plans have detailed, specific, and outcome-focused plans
- ensure that all children in need plans are regularly and robustly reviewed at multi-agency meetings and that particular attention is paid to identifying when concerns are not resolved promptly or improvements are not sustained.

Introduction

1. When the national Aiming High for Disabled Children programme was being developed in 2007 by the previous government it was estimated that there

were 570,000 disabled children in England.³ This programme put in place a range of support for disabled children and their families.

2. The children in need census as at 31 March 2011 showed that there were 382,400 children in need in England of whom 54,100 (14.2%) were recorded as having a disability. At that time 42,700 (11%) children were subject to a child protection plan of whom 1,600 (3.8%) were recorded as having a disability. Children with a recorded disability were therefore less likely to be the subject of a child protection plan than other children in need.
3. The *Special educational needs and disabilities review*, published by Ofsted in March 2010, found that only five of the 22 local areas surveyed took a holistic view of children's needs across children's services.⁴ Where there was a strong commitment to the non-statutory Common Assessment Framework it was effective in coordinating the work of a number of different organisations around the needs of a single child and in making sure that access to services was fairer.
4. The Green Paper, *Support and aspiration: next steps*, sets out a commitment to ensuring services work together to strengthen services for disabled children and young people, and those with special educational needs.⁵
5. Original research in the United Kingdom on the incidence of abuse of disabled children is limited. The most significant research which is repeatedly quoted is a study of more than 40,000 children conducted in North America and published in 2000. This concluded that children with a disability were 3.4 times more likely to experience abuse and more likely to experience multiple abuse.
6. This thematic inspection explored the effectiveness of work to protect disabled children at all stages from early support to the identification of and response to child protection concerns. It examined the actions taken to ensure that disabled children are protected, identifying the key factors which promoted effective protection and the barriers to achieving this. It considered how well local authorities and LSCBs understand the needs of their disabled children population and how they evaluate the impact of the work done across agencies and by professionals to ensure that they are protected effectively. Where case studies have been presented they have been anonymised to protect the families concerned.

³ *Aiming high for disabled children: better support for families*, Department for Education, 2007; www.education.gov.uk/publications/standard/publicationDetail/Page1/PU213.

⁴ *The special educational needs and disability review* (090221), Ofsted, 2010; www.ofsted.gov.uk/resources/090221.

⁵ *Support and aspiration: a new approach to special educational needs and disability – progress and next steps*, Department for Education, 2012; www.education.gov.uk/publications/standard/publicationDetail/Page1/DFE-00046-2012

Methodology

7. This report summarises the findings of a thematic inspection of 12 local authority areas to look at the effectiveness of work to protect disabled children. The local authorities varied in size and geographical context and included metropolitan areas and counties of varying size, with a combination of rural and urban features.
8. Inspectors sought to identify how well child protection concerns about disabled children were identified; how effectively concerns were responded to; and the impact of work with disabled children from early support through to child protection work on keeping disabled children safe and protected.
9. Inspectors visited 12 local authorities. Of these, seven had been judged good and five satisfactory in Ofsted inspections of their safeguarding and looked after children services. On each visit inspectors sampled case records with key workers, social workers and/or managers, examining different key stages of work.
10. Altogether, inspectors sampled 173 cases covering multi-agency prevention and support cases; contacts and referrals to children's social care; initial assessments; child protection enquiries or strategy meetings; children in need cases; and child protection cases. All the case records seen by inspectors were examined alongside key workers, social workers or managers and were fully discussed with them. A breakdown of the cases in terms of age, gender and ethnicity can be found in Appendix B.
11. This thematic inspection sought to trace the child's journey through the system to understand how well disabled children were protected from harm. Inspectors therefore studied the types of cases described above in order to assess how well potential risks and child protection issues were identified and dealt with at all stages of the system, from preventative early support, through the initial contact with children's social care, child in need planning and assessments, through to child protection enquiries, planning and assessments, and occasionally legal proceedings. Inspectors examined records and spoke to a range of professionals and parents to evaluate whether work with disabled children identified needs and risks effectively, reduced risk and offered protection to those children who needed it.
12. Inspectors met with 18 parents, 10 of whom had disabled children with child in need plans and eight of whom had children subject to child protection plans.

13. In each local authority inspectors also met with:
- a multi-agency group of senior strategic managers
 - a multi-agency group of practitioners
 - the local authority designated officer
 - the chair, or their representative, of the LSCB and the business manager for the Board.

The impact of timely multi-agency early support on protecting disabled children

Access to timely multi-agency early support

14. Across all local authorities and their partners commitment to providing disabled children with easy access to the right range of services was strong.
15. Clear pathways were in place to access appropriate professional intervention and support when concerns emerged that a child might have disabilities. But there could be delays in diagnosis, particularly for children with autism and Asperger’s Syndrome. Access to early support usually did not need a clear medical diagnosis or involvement by children’s social care services. In the areas visited, disabled children and their families had access to a wide range of early support services: these included parenting support, short day breaks and outings to leisure activities via a range of provision initially established through the Aiming High initiative. Several parents received support in the form of direct payments.
16. Timely multi-agency early support was usually available when a disabled child and their family needed it, although in a small number of cases parents felt that difficulties had to escalate before the right level of support was put in place. Accessing early support in the first instance depended on parents and carers recognising that they needed support and being willing to accept it. Staff across universal services working with disabled children played a crucial role in identifying disabled children and encouraging uptake of services. Some parents found it difficult to accept that they needed support.
17. Professionals recognised that sometimes there were cultural barriers to accepting support. For example families newly arrived from other countries did not always understand that their disabled children had an entitlement to services and Traveller families were sometimes reluctant to engage. The multi-agency support cases examined by inspectors showed that timely support was provided for many children with complex needs and backgrounds. Some local authorities had commissioned services to make them more accessible and acceptable – for example by providing a choice to attend single-gender

activities that were more acceptable to some families from particular religious backgrounds.

Multi-agency assessment and support

18. All the local authorities visited had clear multi-agency assessment and support processes in place through the Common Assessment Framework and the team around the child. In many local authorities these processes were used effectively to coordinate services. They were used to bring together professionals involved with disabled children to share and tackle concerns at an early stage, working with parents/carers and children.
19. A very wide range of professionals across health services, education services, schools, children's centres, voluntary agencies and private nursery provision were involved in supporting disabled children and their families. The lead professionals and key workers that inspectors met were enthusiastic and committed. In the great majority of cases examined by inspectors they coordinated activities effectively.
20. In the cases examined by inspectors where no current or previous risks had been identified, records showed that the children were living in well-supported home environments with caring, committed parents, who were well motivated to identify and take up the support their child needed to help them to progress and lead a safe and happy life. Work was consistently child-focused but also recognised that helping the parents was a prerequisite for ensuring that the children got the support that they needed.
21. In most cases professionals across agencies worked well together and helped parents to understand their child's disability and the impact of this, and advised them on managing their children's care and behaviour. In cases where the Common Assessment Framework and the team around the child were used well and had clear outcome-focused plans, these enabled agencies and parents to work together effectively to ensure that the right support was put in place and that it responded flexibly to changing needs. There was good evidence from examining records and talking to key workers that outcomes for children had improved.

Case study

Support services for a primary-school-aged child with a serious visual impairment and diabetes were planned and coordinated effectively through the Common Assessment Framework and regular team around the child meetings, bringing together the sensory team; the special educational needs coordinator; the children's centre; a counselling service; the diabetic nurse and diabetic advocate; the school nurse; and the mother. Appropriate equipment was put in place at school to enable the child to access the curriculum fully, and aids and adaptations were provided at home to make the environment easier and safer. The child

was given training in using Braille. Changes were made to the school diet to ensure that the right foods were provided to ensure stability. Counselling has given the child the opportunity to talk about his difficulties.

22. In the initial assessments examined by inspectors in which there were no child protection concerns, assessments were generally detailed and clear and led to appropriate services being put in place to support children and families. In cases where children's social care had had previous involvement, current key workers across a variety of agencies had a good knowledge of the previous concerns and in almost all cases were appropriately aware of their impact on the current situation.
23. In several cases the decision to undertake a multi-agency assessment was triggered by emerging risk issues. The concerns in these cases included: risk-taking behaviour and aggression towards siblings; missed health appointments; not ensuring that children used appropriate aids; poor housing which was directly affecting health; risks of sexual exploitation; and very poor school attendance. These cases showed a clear focus on the child and a good understanding by professionals of the particularly negative impact on disabled children when there are concerns regarding the quality of parenting. In two cases new child protection concerns were appropriately identified in the course of the multi-agency support work. Good progress was often made in resolving or significantly reducing the identified risks through effective multi-agency working.

Case study

There were increasing concerns that the development of a child diagnosed with a significant hearing impairment and subsequently with sight impairment was being avoidably impaired through the parents' reluctance to help their child to use hearing aids and spectacles. There were also concerns that the child was not eating sufficiently. The parents were socially isolated and resistant to support. The child's health appointments were cancelled. The peripatetic teacher for the deaf took the role of the lead professional and coordinated an action plan with the teacher for visual impairment, the health visitor, the nursery teacher and the social worker for the deaf to tackle the concerns. Patient multi-agency work with the parents resulted in significant improvements for the child who now uses the aids, attends a pre-school setting regularly and has made good progress overall.

24. Effective individual work with young people had a positive impact on reducing risk.

Case study

There were concerns about a young person's risk-taking behaviour. He was playing with fire and being aggressive towards siblings and at school. The senior adolescent and community support worker was identified as the key worker. He met the young person weekly, and helped him to identify the problems and express his fears of being excluded. The key worker challenged the young person about the effects of his behaviour and identified how he could change positively. The key worker prepared him for meetings at school to discuss his education. As a result the young person became much calmer and moved to a school that better met his needs.

25. In a small number of support cases, despite the efforts of involved professionals, progress was limited and concerns had escalated, leading to the child being referred to children's social care services.

The identification of, and response to, child protection concerns

The identification of child protection concerns by professionals and agencies

26. A very wide range of staff from a variety of agencies made appropriate and timely referrals to children's social care, demonstrating a good awareness and understanding of child protection. However referrals had not been analysed by local authorities to consider if the proportion relating to disabled children reflected the proportion of disabled children within the local area. This meant that it was very difficult for local authorities to know if there were children within the community with unidentified risks to their safety.
27. In most cases where families were receiving early multi-agency support, professionals were alert to risks and acted appropriately and at the right stage to refer concerns to children's social care.

Case study

A health visitor was concerned that a young child with a physical disability had missed health appointments. The mother had several other children and was struggling to cope. Professionals had tried to support the family through Common Assessment Framework and team around the child but this had not been successful. A detailed initial assessment was completed which involved a wide range of professionals, and appropriate support was put in place which successfully engaged the mother and resolved the concerns.

28. However, in a small number of early support cases child protection concerns had not been identified and referred to children's social care appropriately or promptly. In one case a potential child protection issue of alleged serious risk to a sibling was not followed up. In another case there were delays in escalating concerns regarding non-attendance at health appointments. In this case the seriousness of the situation did not appear to have been grasped by the professionals involved and there was an over-emphasis on supporting the mother rather than a clear focus on improving outcomes for the child.
29. Inspectors found that where children were receiving services from children's social care under child in need procedures there had too often been delays in recognising that the threshold for child protection had been met. Most of these cases related to neglect concerns. For example in one such case, which had been opened and closed on a number of occasions, the impact of poor parenting on the disabled child in the family was not clearly identified until a manager from the specialist disabled children team became involved. This child had a history of repeated hospital admissions due to failure to take medication. In addition there was a history of non-attendance at health appointments. In another case a young person with autism was receiving support as a child in need. However, it was not until an investigation was undertaken into allegations that a sibling had been sexually abused by a family member that serious concerns regarding neglect were identified for this young person.
30. In other cases indicators of risk, such as repeated avoidance of social work visits, were missed when there were already concerns regarding the quality of parenting or a failure to assess known risks. For example in one case the mother of a child with learning difficulties was supported by a family support worker. The mother began a relationship with a young man who had a history of violence. The Youth Offending Service alerted children's social care but no assessment was undertaken until an incident of domestic violence was reported some seven months later.

The response to child protection concerns

31. When concerns about risks to children were referred to children's social care, in the majority of cases appropriate and timely decisions were taken to assess and investigate the concerns. However, in a sizeable minority of cases decisions were taken that no further action was needed by children's social care. These decisions were not appropriate given the extent of the concerns. In most of these cases there was a history of concerns including domestic violence, neglect or parental mental health difficulties. In these cases the critical issue was the failure to draw together and take account of previous history including consideration of why previous work done, sometimes through multi-agency support or early intervention teams, had not been successful in resolving the issues. In some cases details of the preventative support work undertaken through the Common Assessment Framework and the team around the child were not readily available to children's social care and as a result did not inform decisions. Concerns in these referrals included: younger children being left in

the care of a young teenage boy with autism; parents repeatedly not taking up health appointments; parents struggling to manage their children with escalating concerns for their welfare and safety.

32. Several of the initial assessments examined by inspectors related to possible child protection concerns. There were significant shortcomings in most of these assessments; previous concerns were not taken into account and there was insufficient focus on, and analysis of, risk factors.
33. For example in one case a teenage girl with learning disabilities was appropriately referred by her special school when they discovered that she was pregnant. An initial assessment was promptly undertaken but did not explore sufficiently the circumstances leading to the pregnancy or assess the capacity of the young person's parents to keep her safe. The assessment highlighted concerns regarding the home conditions but did not provide a clear analysis as to whether this posed a risk to the young person's well-being. There was little evidence of the views of other professionals informing the assessment. The focus of the work thereafter moved to assessing the needs of and risks to the unborn baby, while the needs and risks associated with the disabled young person were not properly assessed.
34. In the best assessments risks were thoroughly assessed.

Case study

Allegations were made by a father that his ex-partner had been sexually abused by a family member who was in contact with his child. The assessment focused clearly on establishing how well the child was cared for and protected. It was well informed by the views of the police, the probation service and the health visitor. Full account was taken of the family's previous history and careful consideration was given to the context of the allegation. The potential risks were thoroughly explored and the child was safeguarded.

35. When child protection enquiries were undertaken they were usually thorough and in the cases examined they were carried out by social workers with appropriate experience and expertise in child protection and disability. However records did not always clearly reflect the work done. Strategy discussions and meetings were held promptly but too often records did not show how the child's views would be sought, or explicitly consider the impact of the child's disabilities. Child protection medical examinations were undertaken when necessary. Appropriate steps were taken to ensure the immediate safety of children. In the best investigations good work was done to get the views of children and young people.
36. In the large majority of cases, decisions regarding future actions needed to protect and support children were sound and made following appropriate

investigations. A significant number of the cases were taken to child protection case conferences and in two cases children became looked after.

37. A particular feature of child protection enquiries involving disabled children was that in the large majority of cases the children were already known to children's social care and receiving services as children in need, or were already subject to a child protection plan. This meant that the social workers undertaking investigations usually knew the child and family. The impact of this on effective child protection work was hard to discern, however, as will be seen below; where children had been known to children in need teams for some time, child protection concerns often went unnoticed.

The effectiveness of children in need work in preventing child protection concerns arising or escalating

Assessments and planning

38. In the child protection cases examined by inspectors almost half of the children subject to child protection plans had previously received services as children in need. In some cases the children in need work had not been effective in resolving long-standing child protection concerns. Most of these cases involved neglect. Too often, insufficient attention had been paid to recognising the reality of the unacceptable conditions children were living in.
39. Efforts to tackle the problems in these cases were ineffectual. Professionals were sometimes over-optimistic when improvements were made, failing to take into account the parents' history of inability to sustain progress. In some cases families had moved between different local authorities, making detailed assessments more difficult. Sometimes maintaining a firm grasp of the risks was hampered by changes of social workers and managers. In one case the failure to put in place well-coordinated child in need support for a child with autism meant that concerns escalated and ended in the child being subject to a child protection plan. These difficulties were further compounded by a lack of regular and rigorous reviews in many cases.
40. Sometimes poor parenting was masked by large support packages. For example in two cases almost all the day-to-day care for young people with very complex needs was provided by carers and not by the young people's parents. When the parents were responsible the quality of care dropped to unacceptable levels.
41. In most of the current children in need cases examined by inspectors there were no child protection concerns. In these cases assessments were generally thorough but not always up to date. The best assessments provided a very clear picture of the child, the family and the child's place within the family. The impact of the child's disabilities on the child, siblings and parents was described and assessed in detail, with good use of information and assessments from other involved professionals. The analysis of needs was clear and included any previous risk factors. Appropriate recommendations were made based on the

assessments to identify the support and intervention needed to keep the child well supported.

Case study

A young boy with learning difficulties attended a local special school. He had a package of support which included some regular overnight stays. However the parents were feeling under increasing stress and were considering that their son might need long-term residential care. The original assessment was clear and thorough. Safety issues for the child were very clearly identified regarding being bullied and vulnerable in the community and being targeted by children locally. There were no concerns regarding parenting but good work was done to help parents think about ways to ensure the child's well-being when playing outside. The package of support was re-assessed and additional support put in place through increased respite and direct payments which enabled the young person to have better access to leisure resources. As a result the situation calmed and the child was supported to remain at home where he wanted to be.

42. In the best cases assessments were updated to take account of changing circumstances. However in a significant minority of cases, assessments which had been completed between one and three years before had not been updated. As a result it was not clear if the support originally identified still reflected the current needs.
43. Most children in need cases had up-to-date plans based on assessments. However almost half of these plans were not sufficiently detailed or focused on outcomes; this made it difficult to monitor progress. In a small number of cases there were no plans in place and as a result there was no adequate review of the impact of the work.
44. In the best cases plans were reviewed regularly by independent reviewing officers or managers, with good attendance by involved professionals.
45. The importance of this was evident when inspectors spoke to parents. One parent said agencies have to

'...stick to the plan, they are governed by it; they have to account for what they've done or not done. The difference it's made is incredible. The plan is forward-looking and thinks of future needs.'
46. However, in over a third of children in need cases examined, reviews were either not held regularly or when they were they did not involve other agencies. In these cases this lack of effective multi-agency working had a negative effect on the quality of information sharing and effective joint working.
47. For example in two cases in which a child was excluded from school there was no effective multi-agency intervention to identify and minimise the risk of school exclusion. When the child was excluded from school this put enormous

pressure on the parents. In one case there was a risk of the child becoming looked after. This had been successfully averted through an extensive package of day-care support although the child was still without any educational provision. In the other case very limited support was provided. In a third case the agreed support was never put in place due to the lack of a suitable carer and no alternatives were offered. This issue was not picked up as the case had not been reviewed.

Outcomes

48. In almost all of the open child in need cases examined by inspectors, parents recognised or accepted that they needed support and were keen to take up offers of help. In most cases the support provided helped to resolve specific problems and/or reduced parental stress and anxiety by giving them a break from their caring responsibilities.

Case study

A deaf and blind child with learning difficulties screamed constantly causing the whole family great distress. A comprehensive assessment was completed with good analysis well focused on the pressures, needs and risks. There were good observations of the parents' behaviour management strategies. A detailed child in need plan was drawn up with the parents and all the key professionals and was regularly reviewed. The involvement of the sensory impairment support team played an important role in helping parents and professionals better understand the root cause of the child's distress and to develop strategies to ensure that the child was consistently handled calmly and sensitively. Overnight stays and access to leisure activities were arranged for the child. This had the added benefit of enabling the parents to spend additional time with their other children and alleviated stress on the whole family.

49. However, the impact in some cases was difficult to see. In some cases key presenting problems remained unresolved – for example inadequate housing or severe sleep difficulties. In other cases the lack of up-to-date assessments and plans meant that there was no evaluation of the impact of the services that were being provided.
50. In some cases extensive packages of support were in place. In other cases parents' knowledge that they had easy access to a known and trusted social worker, with whom they could discuss problems and stresses, played an important part in how well supported they felt. The mother of a child with global developmental delay and a life-limiting medical condition told inspectors that while she seemed to be coping on the surface she did not always feel that she really was. She found the support from the social worker really helpful:

'If it wasn't for the social worker I would probably be in a bad place. I know she is there when I need her. I can pick up the phone when I am

having a bad day and really struggling. I always get a response when I need it.'

51. Some of the children in the open child in need cases had previously been subject to child protection plans. When the risks had reduced, these cases had stepped down from child protection to child in need. In these cases the previous risks had been analysed well and the cases were managed appropriately under child in need plans. Social workers showed good understanding of the risks and the need for constant vigilance in the light of the previous, often very substantial, child protection concerns.

Case study

Both parents had a history of alcohol and substance misuse and had neglected their children. The father successfully resolved his addiction problems through attending a rehabilitation clinic and now had full-time sole care of his children, one of whom had physical and learning disabilities and used a wheelchair. The mother was still using heroin and her whereabouts were not known. The social worker had used the case record to ensure that she had a full understanding of the history and she was alert to the risks. She worked well to engage with the father and recognised his strengths. Day-to-day communication between professionals and with the father was good. This ensured that there was an effective network in place to identify any problems early and put in place plans to tackle them.

The impact of child protection plans in reducing risks and resolving safeguarding and child protection concerns

Assessments and planning

52. All the children subject to child protection plans had plans which were regularly reviewed. The best plans set out the risks to children very clearly. They included specific actions and measurable targets and timescales as to how the risks were to be tackled, what people's responsibilities were and what outcomes the plan aimed to achieve. They also set out in unambiguous terms the consequences of failing to make progress in reducing the identified risks. In some cases written agreements with parents were also used well. These spelt out in detail what they were expected to do to improve the situation for their children.
53. The majority of plans, however, did not meet this standard. While progress appeared to be happening in the majority of cases, the lack of outcome focus in plans made it difficult to assess the impact of the work by professionals and created the possibility that progress was judged by activity rather than the

difference this had made to improving children's safety and well-being. In some cases plans were too broad and lacked sufficient detail or clear timescales.

Outcomes

54. In the majority of cases good progress was made in tackling the identified child protection risks effectively and ensuring children's safety. A number of features contributed to this positive progress.
- In some cases the very fact that their children were made subject to child protection plans enabled the parents to face up to the serious impact on their children of their failure to provide good-enough parenting.
 - Social workers were persistent and tenacious and built positive relationships with parents, challenging and supporting them to make the changes necessary.
 - The provision of tangible practical support, such as short breaks, aids and equipment, helped to build trust with parents.
 - Outreach support helped to build parenting skills.
 - Well-coordinated multi-agency working ensured that information was shared well and there was a consistent approach between professionals.
 - Progress was carefully monitored and contingency plans were followed through when progress was not made.

Case study

In this case there were concerns for the health and well-being of a child who was a wheelchair user with learning and physical disabilities, who also had additional complex health needs which required regular involvement by health professionals. There were concerns that the child was not attending health appointments consistently and not attending school regularly. There were also concerns about the poor personal care given and about the child being dressed inappropriately. These concerns were not resolved over the period when the child was subject to a child in need plan. However, since a child protection plan has been established there has been demonstrable progress: all routine and specialist health appointments have been kept and there have been improvements in day-to-day care. The social worker is very mindful of the history in this case of improvements not being maintained and is vigilant in monitoring progress. The social worker described maintaining 'a healthy scepticism' and looked for real evidence of progress rather than relying on what was said.

55. In some cases identified risks did not diminish in spite of good plans and well-coordinated efforts by a range of committed professionals. Sometimes situations were so complex that there were no easy solutions.

56. In those cases where there had been no significant progress the main contributory factors were:
- delays in finding suitable alternative carers to meet children’s very complex needs
 - parents’ avoidance and lack of acknowledgement of the concerns
 - delays in putting appropriate support in place or resolving school attendance issues leading to an escalation of stress and risks in the family
 - a lack of effective, detailed and outcome-focused plans resulting in ineffective monitoring of progress.
57. In those cases where risks were not reduced and outcomes for children had not improved, decisions had been taken to instigate legal proceedings. In most cases, although not in all, these decisions had been made at the right stage.

The views and feelings of children

Consultation

58. Local authorities consulted with disabled young people with regard to services and support but specific consultation with disabled children regarding child protection is more unusual, although there were examples of this.

Case study

One LSCB had consulted disabled children on their understanding of what safeguarding and child protection meant to them. From this it emerged that they did not know about sexual abuse and neglect and all had absolute trust in adults. This highlighted their vulnerability to abuse. This work informed the development of an intimate care policy and the children’s views have been included in training on safeguarding disabled children.

Ascertaining the views and feelings

59. In the cases examined, inspectors found wide variation in how well the views and feelings of disabled children were sought, recorded and made a difference. The extent to which a child’s disabilities affected their ability to communicate was very variable and was not always made clear in records. Some children communicated well, some communicated only to those who knew them well. Some children did not understand the concerns about their care and safety, others did. Gaining a picture of the world of a child with profound disabilities was challenging and usually depended on the observations and views of their closest carers.
60. In cases where the views and feelings of children were captured effectively, staff knew the children well. They understood how the child liked to

communicate and, where appropriate, used tools such as picture exchange, electronic widdits and basic signing to capture children's views.

61. Some case records showed no evidence of the children's views being sought and no reasons were given for this. In other cases there were limited observations of the day-to-day lives of children with profound and complex needs, making it difficult to see life through their eyes. Contact between the child and social worker was limited in some children in need cases, and not enough use was made of information from professionals who knew the child well and were well placed to advocate on a child's behalf. Limited use was made of independent advocacy services.
62. In cases of children who could not communicate directly and those who had profound and complex disabilities, careful and close observation by people who knew the children well was key to getting a picture of children's lives and interpreting behaviour. In some cases social workers worked closely with staff from other agencies who had regular daily contact with children to gain children's views; these included teaching assistants, learning mentors, carers and nursery staff.
63. In one case of a child with multiple disabilities which included cerebral palsy, visual impairment, reflux, seizures and hearing impairment, the social worker described how the child displayed his likes and dislikes and had learnt to recognise when he was in discomfort. From small and incremental changes she could see how his development was progressing, and could deduce that he was comfortable with his mother and receiving good care.
64. Cases examined by inspectors showed good examples of how finding out what children and young people wanted led to services and support better tailored to meet their needs.

Case study

An academically able young person with a physical disability and Asperger's Syndrome did not want to attend case reviews but instead prepared a PowerPoint presentation setting out her views and feelings clearly and powerfully. This showed the huge impact on this young person of constantly trying to control and manage her difficulties:

'I'm different from other people because I see things differently and think differently. At school I agree on terms that make them happy and make their job easier and my life harder. I need a structured routine; I like to know details, even the tiniest detail. I worry all the time about everything and a lot more. I struggle with eye contact and physical contact like hugging. If anything disrupts my routine I don't like it at all. I need things explained clearly to me.'

With the young person's agreement the presentation was shown to all class teachers to raise their awareness of the difficulties the young person faced and what they could do to help.

65. Loneliness and isolation can be a problem for older young people. They are more reliant on the adults caring for them and staff supporting them to help them engage with peers.

Case study

A young person with autism and learning disability had moved from special school to college and was unhappy. The key worker's careful and sensitive work found out that the young person was missing a friend from school and the parents had not done anything to sustain this friendship. The key worker sought out the friend and with parental permission included both young people in sport and leisure activities, maintaining the friendship.

66. Professionals who knew children well helped to ensure that their views were sought and often acted as effective advocates for them. In one case it was recognised that an independent advocate would be useful and a care worker who knew the young person well was being trained in advocacy. An independent advocate was used in one case to help represent a young person's views at a case conference.
67. A formal independent advocacy service is not available in all areas. Where it was available some social workers had thought about using it but concluded that introducing another person into the child's life would not be helpful as the child's views were well known already. In these cases that was usually appropriate. But in most cases no consideration was given to using an advocate even though this would have been useful in a small number of cases examined.
68. Where children were able to understand the concerns but did not agree with the plans to safeguard them, this was made very clear. For example in two cases the plans were to place the children away from home and the children wanted to remain at home.
69. In the best child protection enquiries careful consideration was given to gaining children's views about the risks to them, and in some cases their views were explicit. For example in one case a child said:
- 'Mummy whacks me and Daddy does it worse... It really hurt; I wish that Daddy's hand would freeze.'
70. Going at the child or young person's pace and working closely with other professionals who know the child well were often critical to enabling the child's views to be heard and enabling secure evidence to be obtained.

Case study

A young person with learning difficulties made an allegation of sexual assault by a neighbour to staff at the residential unit where overnight respite care was being provided. The allegation was referred immediately and a strategy meeting was held promptly involving the police, the social worker, the short breaks unit manager and the manager of the children with complex care needs team. The investigation was carefully planned. The needs of the young person were very well addressed and a great deal of sensitivity was displayed in the work to ensure full engagement in the process without adding any anxiety or distress. A police officer worked closely with a staff member from the short breaks unit to build the young person's trust. As a result they secured an effective interview which led to the arrest of the alleged perpetrator.

71. Strategy discussions or meetings do not generally give sufficient explicit consideration to obtaining the views of disabled children and there were limited examples of good detailed planning to interview children. When specific concerns were being investigated children were not always spoken to directly even when it was evident from the files that they were able to communicate clearly.
72. In child protection enquiries many of the police interviewed by inspectors felt that it was difficult to obtain robust evidence from disabled children to enable prosecutions to proceed. However in five local authorities inspectors were given examples of cases in which allegations of child protection concerns by disabled children had led to prosecutions. All of the cases involved sexual abuse.

Parental involvement and views

73. Staff worked effectively with parents and their views were clear. Parents were generally involved in reviews and meetings about their children. There were many good examples of sustained and sensitive work with parents to help them understand and accept the right support for their children. There was good evidence of key workers from a range of agencies acting as effective advocates for parents, for example in helping them to negotiate for suitable housing to meet the family's needs.

Case study

A very young child with serious and potentially life-threatening physical health problems lived with both parents and several older siblings in a two-bedroomed flat. The mother and the child were sleeping on the floor in the living room. The child vomited constantly. The key worker drew on his previous experience of the housing sector very effectively and called an urgent meeting with the right level of seniority from housing services

to discuss the risks to the child of the family's inadequate housing situation. This led to the family being moved to a bigger property adapted to meet the child's needs.

74. Most parents spoken to by inspectors whose children had children in need plans were very clear why their child had a plan and described in detail what led to plans being put in place. Most parents felt that they received good support now and this helped them to cope.

Case study

A single father cared for his young child who had autism and slept very little. The father noted the benefits to both him and the child of the positive relationship they had with the child's carer. He said the child loved going to the carer: 'It is a positive thing to have another adult, especially a female, in my child's life.' For the father it meant that he could get some sleep and so felt more able to look after his child. He was happy that his views were respected and that professionals listened and acted on what he said in relation to handling his child.

Case study

A mother and her teenage child had a difficult relationship and there was a risk that this might escalate to the young person being, in the mother's words, 'hit and slapped'. The mother said the relationship with her child had improved because of the support that she and her child had received. The young person now attended a youth group and was learning to cook. The mother also received 17 hours a month babysitting service so that she could go out alone at the weekend or in the evening. In addition her house was now fully adapted.

75. Other parents said:

'The plan has made a phenomenal difference; I am a lot less stressed.'

'Amazing really, I can't fault them... [the social worker] is very proactive, we didn't realise how supportive they can be.'

76. In most cases parents felt that agencies worked well together. Effective and regular reviews played an important part in this. One parent said:

'The reviews are in depth and it's such a difference having someone coordinating the services and make [agencies and professionals] stand up and be honest.'

77. However in some cases work between agencies was not well coordinated and parents found this frustrating and unhelpful. One parent said that social care and occupational therapy:

'Do not pull together and it is frustrating having to retell your story or issue to different people over and over again.'

78. Four parents had experienced delays in getting the help they needed; getting the right aids and equipment had been a particular problem.
79. In one case there was a waiting list for overnight care due to the shortage of carers. One of the parents talked about having to fight for the help she needed in the past. Two parents had never seen a plan and one parent did not know her child was subject to a plan. In this case the mother organised all her own support through direct payments. This support had not been reviewed and the mother said she would have welcomed multi-agency support.
80. Most parents spoken to by inspectors whose children had child protection plans had a clear understanding of the reasons their children were on a plan and accepted that this was necessary. Of this group most felt that the plan had made a real difference and they highlighted support which had been particularly helpful.
81. In one case where there were concerns about neglect a mother said that having her child on a child protection plan helped her to see the seriousness of what was happening. She said that with help she had improved things at home. The social worker helped her to be organised so that she did not miss her child's appointments and knew how to ring and rearrange them. She said one of her problems had been not asking for help and that she could now see that there were people to help her and that she needed to accept this help. A meeting (a family group conference) was also held with her family which helped her to ask them for help. The child is taken out by a carer once a week and in school holidays; the parent said, 'This works really well, they go to the park and the cinema.'
82. In another case parents praised the parenting course they had attended at the children's centre:

'It was brilliant, it really makes you think. They talk over things, really polite, we can speak with them.'
83. Two parents felt that they did not get the help they needed until the child protection plan was put in place. In one of these cases this was confirmed by the case files. Two parents did not agree that their children were at risk and did not agree that they needed a plan. In two cases there were ongoing issues regarding children excluded from school which parents were very unhappy about. They felt that this was a central problem and that the child protection plan had not helped to resolve this issue. These concerns were corroborated in the case files.

Leadership and governance

Evaluation and quality assurance

84. Despite having access to a large amount of data regarding disabled children most local authorities and LSCBs had not made good use of this to assist them in evaluating the impact of services on protecting disabled children. Even in local authorities where the profile of disabled children was high, with dedicated LSCB sub-groups, this in itself did not ensure sufficient scrutiny of the quality of practice with disabled children, particularly of early support and children in need work.
85. Multi-agency strategic planning for disabled children was generally well established and there was a good understanding of the profile of the disabled children based on detailed audits of needs. However, in most local authorities data was not routinely gathered and analysed to explore how well disabled children were protected. While almost all local authorities and LSCBs expressed confidence in the quality of the work to protect disabled children, most had not established robust quality assurance systems across the whole spectrum of work with disabled children to evidence this confidence.
86. Most LSCBs were presented with data on the numbers of disabled children subject to child protection plans. Some LSCBs recognised that the numbers were low and not in proportion to the number of disabled children living in their area, but many had never discussed this issue.
87. LSCBs all had one or more board members experienced in working with disabled children in their professional lives. Most had identified specific members with responsibility for leading on safeguarding and protecting disabled children and had active sub-groups supporting this work. This helped to ensure recognition of the additional vulnerabilities of disabled children and there were examples of this leading to tangible outcomes.

Impact of LSCB: good practice example

The LSCB ensured that a clear and continued focus on protecting disabled children was maintained. The senior manager responsible for the integrated service for children with additional needs sat on the Board. This ensured that the needs of disabled children were on the agenda and the implications for them of any plans and actions were routinely considered. The LSCB had a well-established sub-group leading on safeguarding disabled children. This group identified that there were low numbers of disabled children with child protection plans. It focused on raising awareness of disabled children's vulnerability to abuse through the LSCB conference and training programmes. This resulted in a significant increase in the volume of child protection enquiries.

88. Most local authorities and LSCBs, however, had not done any analysis of the reasons for the low number of disabled children subject to child protection plans. They had not evaluated the quality of support and intervention across agencies for disabled children and the impact of this on protecting disabled children. They had not commissioned any audits across individual agencies to explore if professionals were appropriately identifying child protection concerns for disabled children. Local authorities had not examined referrals to see if the number relating to disabled children was in line with the percentage of disabled children in the area. They had not explored the response to referrals relating to disabled children to establish if thresholds for child protection were applied appropriately.
89. In most local authorities insufficient scrutiny and attention were given to examining the quality of work with disabled children who were receiving early support or support as children in need. Only three local authorities had undertaken audits of all children in need work in their disabled children teams. As a result two were confident that thresholds for child protection were recognised and applied. The third local authority recognised shortcomings and took appropriate steps to strengthen the quality of child protection work with disabled children, which were beginning to have an impact.
90. Most local authorities and LSCBs did not have a clear understanding of the quality of child protection work with disabled children and the impact of this on keeping them safe. All local authorities undertook regular audits of children subject to child protection plans, which included disabled children, but most local authorities did not separately analyse and report on findings from file audits of cases involving disabled children to the LSCB or to senior managers.
91. Some LSCB sub-groups for disabled children had undertaken case reviews involving disabled children cases where there were concerns regarding aspects of practice.

Practice review

This review examined work with the child and family over the period when the child was a child in need and prior to the child becoming looked after. Particular attention was paid to the recognition of safeguarding concerns and the effectiveness of multi-agency working. The review identified a number of significant areas for improvement in working with disabled children: these highlighted in particular the need to ensure that safeguarding issues are clearly identified and are not lost in focusing on supporting the parents; also the need to maintain a clear and strong focus on the child's needs and the need for professionals to be able to challenge each other. Findings were reported to the LSCB and appropriate recommendations were made arising from the identified issues.

92. All local authority designated officers (LADOs) reported regularly to the LSCB and to senior managers on allegations made against staff, carers and volunteers working with or caring for children. However most did not report specifically on the number of allegations involving disabled children or analyse trends and issues. As a result, issues of under- or over-reporting of allegations involving disabled children had not been identified. Some areas noted the difficulty of analysing trends as the numbers were so low but had not asked why they were so low. Where LADOs had undertaken an analysis the benefits were evident in identifying and tackling issues of practice.

Example of analysis

In one local authority, examination and analysis of allegations identified rising numbers of referrals to the LADO from a specific health service provision. This triggered work with the setting to explore the reasons for this and action was taken to address them. In this case key contributory factors to the increase were a change in management and increased occupancy levels.

93. Some LADOs included case studies on disabled children in their annual reports to demonstrate their particular vulnerabilities to abuse and highlight the steps taken to reduce identified risks.

LADO: learning from a case

One LADO report included a case study of a disabled child who had made allegations about rough handling by an escort. No further action was taken on the specific incident, but the investigation identified issues regarding the quality of training for escorts and drivers responsible for transporting disabled children; additional training was put in place to address this. Arrangements were also put in place to ensure a proper handover between schools and transport at the end of the school day.

Service planning and structures

94. Across all local authorities and their partners there was a strong commitment to enabling disabled children to have easy access to the right range and level of services. Multi-agency working was well developed. All the local authorities had well-established specialist disabled children's teams; some of these included other professionals such as occupational therapists. Three local authorities had developed an integrated service for disabled children with specialist teams working together and in some areas specialist teams were co-located. Professionals working in these areas felt that such arrangements improved good communication. In a number of local authorities disabled children received support and intervention at different stages from a range of children's social work teams.
95. Where service planning was strong, information was gathered and analysed on the numbers of disabled children, the range of disabilities and the services they

received; data was used from different services such as health services, schools and children's services. Information was broken down by disability type, age and ethnicity, and often by ward locality or postcode area, enabling services to be delivered, developed, commissioned and targeted to meet identified needs more effectively. However, shortcomings in the quality and detail of recording of children's disabilities could affect the accuracy of this data. In many local authorities it was not mandatory to complete details of a child's disabilities on the electronic children's social care system, and in some cases there was a lack of, or limited, recording of children's disabilities.

96. A number of local authorities gathered and used data intelligently to ensure equitable access to services to support disabled children from all backgrounds. For example, one local authority undertook a joint needs assessment between children's services, health services and its large minority ethnic community to identify unmet needs within that community. This assessment identified a rising population of children and young people with a high incidence of special needs and triggered work to develop, provide and promote culturally acceptable services for this community.
97. Inspectors saw a large number of specific examples where information about the profile of disabled children and the takeup of services was used positively to shape services to meet needs more effectively. For example, in one local authority analysis of the takeup of services by ethnicity led to recognition that lower numbers of minority ethnic families with disabled children accessed services. This led to a decision to contact families directly to offer services to them after diagnosis rather than waiting for them to request support.

Knowledge and understanding of protecting disabled children

98. Professionals across universal and specialist services who met with inspectors showed a keen awareness of child protection issues and understood their responsibilities in identifying concerns. They had a good grasp of the challenges in balancing the needs of children with the needs of parents for support. They were alert to the dangers of collusion. They recognised that sometimes empathy can cloud judgement and staff highlighted the importance of supervision and support in helping to see risks clearly. Inspectors found that this good understanding was demonstrated in many cases but not in all.
99. The majority of staff working with disabled children have received specialist training in safeguarding disabled children. Multi-agency safeguarding and child protection training usually contained specific reference to disabled children. In most local authorities, LSCBs also commissioned specific training on safeguarding disabled children. The large majority of social work staff had undertaken specialist training on safeguarding disabled children, but this still left almost one third of social work staff who worked with disabled children without specialist training.

100. The majority of key workers and lead professionals responsible for coordinating support in cases examined by inspectors had undertaken specialist training in safeguarding disabled children. Some of this had been delivered within their own agencies. However 40% of multi-agency staff had not received specialist training.
101. While details of professionals' attendance at training were collected and reported, only two LSCBs had analysed what proportion of staff had undertaken training on safeguarding disabled children. The vast majority of local authorities visited did not analyse the impact of training on improved practice. Only one local authority was in a position to link improved takeup of training to improved identification and response to safeguarding and child protection concerns.
102. LADOs delivered training to a wide range of agencies and professionals to promote awareness of their role. This was to ensure that staff understood their responsibility to refer concerns regarding the behaviour of staff, carers or volunteers working with or caring for children. Links with schools, including special schools, were particularly well established. However this work did not extend to all residential special schools. Even though not all such schools had made referrals to the LADOs over a 12-month period, this did not prompt LADOs to make contact with these schools to ensure they were aware of their responsibilities to refer concerns to the LADO. In some areas it was recognised that more work needed to be done with specific sectors as they never made any referrals, raising questions about their understanding and application of LADO procedures.
103. There was anecdotal evidence that the numbers of referrals or requests for consultation with LADOs rose following a training event on managing allegations. However, this has not been systematically evaluated. There was increasing awareness of the challenges of ensuring that allegations against staff recruited by parents through direct payments were managed appropriately, although strategies to tackle this had not been developed.

Conclusion

104. For most disabled children, as for their non-disabled peers, there are no concerns about the quality of care they receive, but many need additional support to help them with their daily lives and to make good progress.
105. Effective, well-coordinated multi-agency support delivered to disabled children and their families at an early stage helps to ensure that emerging concerns are identified. Evidence from the inspection showed that in most cases problems were tackled effectively before they became entrenched. A small number of disabled children, like their non-disabled siblings and peers, live in homes where they are not well cared for or kept safe and secure. These children need additional intervention by children's services to ensure their safety and well-being.

106. The survey also found that where there were clear-cut child protection concerns about disabled children, these were identified promptly and investigated appropriately. When disabled children were made subject to child protection plans, effective and well-coordinated action was taken to reduce the risks. But when concerns were less clear-cut, too often the right decisions, assessments and actions were not taken in time to ensure disabled children were consistently protected. Social workers and other professionals too often struggle to identify when poor parenting slips into neglect and needs a robust child protection response. Disabled children often rely more heavily on the adults caring for them than their non-disabled peers and the impact of neglect on them can be greater. This was not always recognised in time.
107. While local authorities have a wealth of information about disabled children, they have not used this to examine how effectively disabled children are protected. Most LSCBs visited had not rigorously tested their confidence that a good range of services for disabled children ensured their protection. Work with children subject to child protection plans is usually well scrutinised, although few LSCBs commission reports on themes and issues specifically about protecting disabled children. Very few disabled children are subject to child protection plans and most LSCBs have not explored the reasons for this.
108. Most work with disabled children is through early preventative support or children in need services. This thematic inspection highlighted weaknesses in plans for, and reviews of, children in need. For families where there are concerns, these weaknesses in the systems make it less likely that issues will be identified in a timely way and followed up rigorously. This is compounded by the fact that quality assuring children in need work with disabled children through case file audits is not well established.

Further information

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Working together to safeguard children: a guide to inter-agency working to safeguard and promote the welfare of children, Department for Education, 2010, Chapter 6, paragraphs 6.43–6.48;
www.education.gov.uk/publications/standard/publicationdetail/page1/DCSF-00305-2010.

Annex A: Providers visited

Local authorities

Cambridgeshire

Derbyshire

East Cheshire

Gateshead

London Borough of Ealing

London Borough of Bromley

London Borough of Hammersmith and Fulham

Nottingham

Rotherham

Staffordshire

Swindon

Wakefield

Annex B: Breakdown of cases examined by age, gender and ethnicity

Age breakdown

Age Range	Number of children	Percentage
0 to 3	31	17.9
4 to 8	53	30.6
9 to 12	44	25.4
13 to 15	33	19.1
16+	12	6.9
Total	173	

Ethnicity breakdown

Ethnicity	Number of children	Percentage
White	124	71.7
Mixed	11	6.4
Asian/Asian British	18	10.4
Black/Black British	8	4.6
Other	2	1.2
Not recorded	10	5.8
Total	173	

Gender breakdown

Gender	Number of children	Percentage
Female	76	43.9
Male	97	56.1
Not Stated	0	0.0
Total	173	