

# CHSCP Multi-Agency Case Audits

## Disproportionality in SEND Pathways

### 1. Introduction

- 1.1 This summary provides an overview of the *Disproportionality in SEND Pathways* multi-agency case audit (MACA) undertaken in the City of London and designed for the City & Hackney Safeguarding Children Partnership (CHSCP) and the City of London SEND Programme Board. It was commissioned to understand if all children receive the right help or if some are treated differently based on background or ethnicity.

### 2. Methodology and Independent Oversight

- 2.1 The MACA was led by Fiona Anderson, Practice Transformation Lead, acting as the independent facilitator and author. The review focused on children with EHCPs, SEN Support, or recent assessments. Due to this small sample size and the strict need to protect the confidentiality of the children involved, the full professional overview report cannot be published and is reserved for governance use by the CHSCP and the SEND Programme Board.

### 3. Multi-Agency Involvement

- 3.1 A wide range of sectors contributed to this MACA:
- **Education:** Local and out-of-borough schools and Educational Psychology (EP).
  - **City of London Corporation Services:** SEND Services, Early Help, and Children's Social Care (CSC).
  - **Health (Homerton Healthcare):** Community Paediatrics, Speech and Language Therapy (SALT), CAMHS, School Nursing, and Health Visiting.
  - **Specialist Services:** Audiology, GP Services, and the Teacher of the Deaf.
  - **Safeguarding & Justice:** Metropolitan Police Service (MPS), Housing, Probation, and Youth Services.

## 4. Key Themes

4.1 The audit identified several areas where structural and practice-based inequities occur. Using the specific wording of the report, these include:

### 4.2 *Identity-Blind Practice*

4.3 Across all cases, ethnicity, language, faith, cultural norms and migration histories were recorded in assessments or referral forms. However, identity was not used to inform analysis. Practitioners rarely explored how cultural background, stigma, trauma or language shaped the child's presentation, parental engagement or decision-making.

**Why this creates disproportionality:** *Identity-blind assessments mean global majority children are more likely to have unmet need, delayed diagnosis, and behaviour misinterpreted without cultural context.*

### 4.4 *Delayed Neurodevelopment and SEND Escalation*

4.5 Neurodevelopment referrals were inconsistently escalated, with some children waiting years for follow-up. Paediatric oversight was uneven, and schools did not always escalate when needs persisted. Children from global majority backgrounds experienced the longest delays.

**Why this creates disproportionality:** *Children with minority backgrounds face more barriers to diagnosis, leading to emotional harm, frustration and escalating school difficulties.*

### 4.6 *SALT Commissioning Caused Direct Inequity*

4.7 Speech and Language Therapy access depended on school purchasing power rather than child need, disproportionately affecting those in smaller or less-resourced schools.

**Why this creates disproportionality:** *Commissioning models tied to school budgets undermine the principle of equitable provision under the SEND Code of Practice, disproportionately affecting children from global majority backgrounds whose schools may not buy in additional services.*

#### **4.8 "Not Brought to Appointments"**

- 4.9 Missed appointments were viewed as a lack of parental commitment rather than a signal of structural barriers like trauma, language, or poverty.

**Why this creates disproportionality:** *Minority ethnic, migrant and refugee families are more likely to miss appointments due to systemic barriers. Without cultural curiosity, children not being brought to appointments become a pathway to under-intervention.*

#### **4.10 Emotional Harm Not Consistently Recognised**

- 4.11 Children from global majority backgrounds were more likely to have emotional distress overlooked or reframed as behaviour. Potential emotional harm was too often interpreted behaviourally or educationally.

**Why this creates disproportionality:** *Children from global majority backgrounds are more likely to have emotional distress overlooked or reframed as behaviour*

#### **4.12 Cross-Borough Transitions Created Drift & Fragmentation**

- 4.13 Children who moved across boroughs (often migrant families) experienced gaps in paperwork, repeated assessments, and delays in service uptake.

**Why this creates disproportionality:** *Migrant families move more frequently, and fragmented systems disproportionately affect their children, causing prolonged unmet need.*

#### **4.14 Inconsistent Multi-Agency Coordination**

- 4.15 Schools often held the deepest understanding of the child's needs, but this insight did not always translate into effective joint planning. Health and SEND updates were sometimes not aligned, and Early Help lacked full context.

**Why this creates disproportionality:** *When systems rely on parental advocacy, children from Global Majority backgrounds are most disadvantaged, leading to inequitable outcomes despite good intentions from practitioners.*

#### 4.16 **Limited Trauma-Informed Practice**

- 4.17 Trauma related to migration, war exposure, displacement and cultural isolation was rarely explored or formulated in assessments.

**Why this creates disproportionality:** *Without trauma formulation, children receive support that focuses on symptoms rather than root causes, prolonging harm.*

#### 4.18 **Over-Reliance on Parental Advocacy & System Knowledge**

- 4.19 The system privileges families with "cultural capital" (those with fluent English and system knowledge) while disadvantaging minority and refugee families.

**Why this creates disproportionality:** *A system that favours advocacy favours families with cultural capital, therefore disadvantaging minority, migrant and refugee families.*

#### 4.20 **Limited Cultural Safety in Health**

- 4.21 Clinical competence was good, but cultural safety was inconsistent. There were low levels of interpreter use, limited cultural contextualisation, and gaps in linking identity to formulation.

**Why this creates disproportionality:** *Cultural safety is essential to equitable health outcomes. Without it, global majority children receive more fragmented support.*

## 5. **Professional Strengths**

- 5.1 Although disproportionality was evident across the cohort, the audit also identified substantial strengths within the City of London partnership. The strengths reflect the dedication, professionalism and relational commitment of frontline practitioners across education, health and safeguarding services. These strengths provide a positive foundation on which improvements can be built.

### 5.2 **Relational Stability**

- 5.3 Schools held the clearest understanding of the whole child and often acted as the anchor when wider systems were fragmented.

**Why this strength matters:** *Schools held the clearest understanding of the whole child and often acted as the anchor when wider systems were fragmented.*

#### 5.4 **Professional Goodwill**

- 5.5 Practitioners across agencies showed care, persistence and willingness to help despite systemic constraints, commissioning limitations and capacity pressures. Health and education staff consistently attempted to “do the right thing”, even when pathways were unclear.

**Why this strength matters:** *Goodwill is not a substitute for system design, but it demonstrates the partnership’s commitment to improving outcomes.*

#### 5.6 **Timely Screening and Identification**

- 5.7 While Neurodevelopmental delays were evident for several children, health services performed strongly in other areas, including hearing tests, school nursing follow-up and speech screening.

**Why this strength matters:** *When pathways are clear and consistent, children receive effective support quickly.*

#### 5.8 **Schools & Health Teams Demonstrated Curiosity & Care**

- 5.9 Although cultural analysis was limited, practitioners demonstrated genuine interest in children’s wellbeing. This relational approach-built trust with children and parents, particularly when families were anxious or unfamiliar with UK systems.

**Why this strength matters:** *Relationships are a protective factor, they increase help-seeking, reduce escalation of harm, and anchor families during periods of uncertainty.*

#### 5.10 **High-Quality Assessments**

- 5.11 Where assessments did take place, the majority were thorough, child-centred and aligned with best practice.

**Why this strength matters:** *High-quality assessments ensure clarity about need, even if system delays occur later.*

### 5.12 **Respectful & Family Centred Early Help**

5.13 Although some families declined Early Help, practitioners approached them sensitively, without pressure or judgement. The tone of communication was consistent with restorative, strengths- based practice.

**Why this strength matters:** *A non-judgemental Early Help offer supports trust and reduces shame, particularly for families facing cultural stigma around help-seeking.*

### 5.14 **Strong Professional Relationships with Children**

5.15 Across cases, practitioners described positive relationships with children, particularly within schools. Children were treated with dignity, patience and respect.

**Why this strength matters:** *Strong relationships protect children from harm, increase resilience, and help mitigate the effects of delayed system responses.*

## 6. **Intersectionality and Disproportionality**

6.1 The audit highlights that disproportionality is not driven by a single factor but by intersecting identities. Children’s experiences were shaped by the combined effects of race, sex, class, migration status, and disability. For example:

- Girls from global majority backgrounds experienced masking of distress, delaying ASD identification.
- Refugee families faced compounded barriers due to poverty, trauma, and language needs.
- Families with lower socio-economic status lacked the cultural capital to navigate SEND systems, amplifying delays.

6.2 Intersectionality matters because these overlapping factors create unique patterns of disadvantage that cannot be understood through a single lens. Addressing disproportionality requires strategies that consider these intersections, not isolated characteristics.

## **7. Anti-Racist & Identity-Informed Practice**

7.1 Anti-racist and identity-informed practice is not an optional extension of good safeguarding; it is a statutory requirement and a core element of safe, proportionate, child-centred decision making. The cases in this audit show clearly that when identity is not fully understood or integrated into assessment, it produces unequal outcomes, delayed support, and harm through omission.

7.2 In a diverse partnership like the City of London, anti-racist practice must underpin every stage of a child's journey identification, assessment, escalation, planning and support. Without it, practitioners unintentionally reproduce inequity even when acting with goodwill and care.

### **7.3 *Without Anti-Racist Practice, Behaviour Is Misunderstood***

7.4 Global majority children often express distress in ways that are interpreted through a racialised or culturally uninformed lens. These misinterpretations delay support, escalate emotional harm, and reinforce disadvantage.

### **7.5 *Trauma Histories must be Integrated, not recorded passively***

7.6 Recording trauma without using it to inform analysis is a recurrent national issue and appeared clearly in this MACA. Trauma alters how children present, how families engage, and how symptoms emerge. Anti-racist practice requires curiosity, not compliance-based judgement.

### **7.7 *Commissioning and System Design can produce Racial Inequality***

7.8 Anti-racist practice also applies to structures, not just interpersonal behaviour. When services rely on local purchasing power, racialised children who attend smaller or lower-resourced schools are more likely to lose access to early intervention. This is structural inequality even when no practitioner intended harm.

### **7.9 *Anti-Racist Practice helps address the 'Advocacy Gap'***

7.10 The audit revealed stark disparities in support pathways. Children whose parents had fluent English, confidence to challenge systems, financial resources for private assessments, and knowledge of SEND processes accessed timely interventions. Neurodevelopmental pathways showed systemic drift for global majority children, with repeated referrals and fragmented assessments.

- 7.11 Embedding identity-informed practice strengthens multi-agency planning. When agencies understand identity, teachers contextualise behaviour, health services adapt communication, SEND teams plan holistically, and Early Help tailors' engagement. This leads to faster, fairer outcomes and reduces drift

## 8. Voice of the Child – Why It Matters, Impact & Change

- 8.1 The audit found that children most affected by disproportionality were those whose communication styles were least understood. Non-verbal, bilingual, neurodivergent, and traumatised children often expressed distress through behaviour, silence, or withdrawal, which was misinterpreted as disengagement or defiance. Strengthening the Voice of the Child is therefore an equality issue, not just a practice principle.
- 8.2 Global majority children faced delayed neurodevelopmental escalation because distress was read as “behaviour” rather than communication. Refugee children’s trauma-related silence was seen as non-engagement. Black girls masked distress, leading to late autism spectrum disorder identification. Bilingual children experienced language-related misunderstandings, delaying intervention. Sensory needs were overlooked because communication profiles were missing. These gaps resulted in prolonged anxiety, missed early interventions, and repeated cycles of unmet need.

### What needs to change

Embed Voice of the Child in All Assessments using multiple modalities: verbal, non-verbal, behavioural, sensory cues, and tools like AAC (Augmentative and Alternative Communication), PECS (Picture Exchange Communication System), and visual supports.

Introduce Mandatory Communication Profiles in every assessment, detailing how the child communicates, sensory preferences, triggers, and what helps.

Standardise Interpreter Use and Recording for families with limited English proficiency to prevent misunderstandings and missed appointments.

## 9. Recommendations for Improvement

Priority	Why Needed	Impact on children	Impact on agencies
<b>Embed Identity-Informed Practice</b>	Identity is often overlooked; racial bias persists.	Accurate understanding of needs.	Compliance with Equality Act.
<b>Strengthen Emotional Harm Responses</b>	Distress is often reframed as "behaviour."	Early recognition prevents escalation.	Better safeguarding performance.
<b>Improve Timeliness</b>	Commissioning gaps cause drift.	Timely access to therapies.	Compliance with Children & Families Act.
<b>Redesign Commissioning</b>	Current pathways disadvantage poorer families.	Equal access to specialist support.	Meets Public Sector Equality Duty.
<b>Support Families with Fewer Resources</b>	Families struggle to advocate without system knowledge.	Improved educational outcomes.	Builds trust; reduces escalation.
<b>Centralise Communication Profiles</b>	Non-verbal/bilingual needs are often ignored.	The child's voice is heard and understood.	Compliance with UNCRC/SEND Code.
<b>Strategic Oversight</b>	Without it, inequities persist.	Consistent quality of care.	Stronger assurance for boards.
<b>Implement Team Around the Child</b>	Fragmented working leads to drift.	Coordinated support; fewer gaps.	Meets statutory duties under WT.

The CHSCP QA Sub group will oversee the development of specific actions to take forward these recommendations.

May 2026