Leicester Leicestershire & Rutland Safeguarding Children Board Learning Event

4th May 2016 – City Hall, Leicester

Safeguarding Babies, SCR's, Role of LADO, Neglect, Voice of the Practitioner

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Welcome.

- **Introductions**
- **Housekeeping (including mobile phones)**
- **Context for the day.**
- **Website – presentation and delegate pack – sharing & embedding learning.**
- **Evaluation forms & certificates**

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Learning from Serious Case Reviews

Presenters:

Chris Nerini (Head of Strategy for Safeguarding Assurance, Leicestershire County Council, Children and Family Services)

Adrian Spanswick (Consultant/Designated Nurse Children and Adults Safeguarding, LLR CCG Hosted Safeguarding Team)

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What is a SCR?

Regulation 5 of the Local Safeguarding Children Boards Regulations 2006

A serious case is one where:

(a) abuse or neglect of a child is known or suspected; and

(b) either — (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

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Seriously harmed

Includes:

- Where the child has sustained, as a result of abuse or neglect, any or all of the following:
- A potentially life-threatening injury;
- A serious and/or likely long-term impairment of physical or mental health or physical, intellectual, emotional, social or behavioural development.

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Cases which must be a SCR

- Where a child dies in custody, in police custody, on remand or following sentencing, in a Young Offender Institution, in a secure training centre or a secure children's home.
- Detained under Mental Health Act 1983 or where a child aged 16 or 17 was the subject of a deprivation of liberty order under the Mental Capacity Act 2005.

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National Panel

- National panel of independent experts
- Advises LSCBs about the initiation and publication of SCRs
- Ensure that lessons are shared through publication of final SCR reports

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Future recommendations

- ‘Serious harm’ to include harm that is caused to considerable numbers of young people in a particular LSCB area

- ‘Serious harm’ to include serious harm to a child in utero where the child is still born

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National SCRs

- 1022 cases currently published going back to 1945 (long before SCRs started)
- 538 since the start of 2010
- Over 69 published in 2015
- 7 in 2016 (so far)

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Themes from National Reviews

- provision of training on neglect and disability
- Information sharing issues between agencies / workers
- Knowledge/ Confidence of staff about young people who express the intent to kill themselves
- Professional knowledge of minority communities
- Effectiveness of Critical Incident Stress Management
- Children being left home alone must be treated as a child protection issue

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National Themes continued:

- Focus of agencies on adults
- Lack of understanding of emerging symptoms of mental health issues in the child
- Lack of understanding and use of carer's assessment and the Common Assessment Framework (CAF)
- Considerations of parents spiritual issues on family functioning and family culture.
- Insufficient professional curiosity given the concealment or denial of mother's pregnancy

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National Themes continued:

- Agencies needed to be more inquisitive, keep consistent records in relation to families
- Tools such as genograms can help with this
- The need for multi agency action plan for CSE/missing backed up by awareness/training for staff

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L&R Learning from National SCRs

- In October 2015 the Leicestershire and Rutland LSCB SCR Subgroup looked at all the National cases published between January and October 2015
- Extracted the recommendations in the SCRs and identified ‘priority areas’ that affect Leicestershire & Rutland
- Presented to the LSCB development day

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Local Themes from SCRs Leicestershire and Rutland 2007-present

- Twenty themes identified
- What is working well in L&R?
- What are we concerned about?
- What do we need to do?

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L&R Local Themes 1

- Young person – Self-Harm
- Escalation of professional differences
- CUSAB
- Child Sexual abuse
- Drugs & Alcohol use by parents
- Parent rolling onto child while intoxicated
- Voluntary agreements with parents/carers

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L&R Local Themes 2

- Effective and safe handover of cases between agencies and case workers in the same agency
- Consideration of 'Think Family' by workers
- Effective sharing of information between agencies
- Effective supervision of case workers
- Identification and management of risky individuals
- Professionals trained to perform their role

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L&R Local Themes 3

- Timely completion of Safe birth plans
- Maintaining Healthy scepticism
- Domestic Abuse in families with children
- Pre-birth assessments
- Injuries to non-mobile babies
- Early help for families
- Effective response by the emergency services to serious incidents involving a child or vulnerable adult

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Identified priority areas for Leicestershire and Rutland 2016/17

- Supervision
- Information Sharing
- The 'Toxic Trio' describing the issues of domestic abuse, mental ill-health and substance misuse
- Young people 'Suicide and Self Harm
- Bruising to non – mobile babies
- Professional scepticism when dealing with parents
- Vulnerable Looked after children
- Transient families

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Next Steps

- Business Plan for the Leicestershire and Rutland LSCB 2016 – 17

- Ongoing work through the SCR Subgroup multi-agency action plan.

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Leicester City Key Learning Themes (1)

- LSCB procedures are good but compliance poor: there is a complacency about knowing what the procedures are, and then adhering to them in practice. There is a lack of reflective supervision
- Purpose of the Single Assessment is not well understood: there is little meaningful information sharing across agencies.
- 'Voice of the child' not sufficient: poor multi-agency understanding of the vulnerability of children in the household where the needs of adults are assessed. · Insufficient escalation and professional challenge: what to do when there is a professional difference of opinion. This is especially topical in health at present.
- Lack of rigour and scepticism assessing risk: explanations too readily accepted and failure to look at circumstances surrounding an incident.
- Poor supervision and management oversight: consider how managers themselves are supervised.

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Leicester City Key Learning Themes (2)

* **Assessment issues: failure to take into account parents' background so over-estimating parenting capacity; poor attention to impact of parental substance abuse & mental health, and to fathers.**

* **Poor management of baby injuries (not following LSCB procedures): poor assessment makes injuries look more benign: as yet there is no mandatory reporting of baby injuries; explanations believed too readily (lack of healthy skeptism); not knowing if child subject to a CP plan – sometimes out of hours access to information but sometimes not asking the right question; frequent 'accidents' not seen as neglect; absence of multi-agency discussion about injuries – lack of compliance round multi-agency meeting that would have triggered action.**

* **Poor partnership working round LAC/CP: failure to use CAF/early help; lack of key meetings and assessments; no collective understanding of pre-existing concerns; signs of abuse/neglect/risk overlooked; poor communication across LA boundaries; impact of DV and adults' mental ill health or substance misuse; weak response to hostile avoiding families astute at non-engagement.**

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Leicester City
Strategic Priority Areas 2015/2017

1. Post Ofsted Improvement Plan
2. Core Business and Governance
3. LSCB Identified Themed Priorities
a. **Evaluating Early Help**
b. Strengthening CSE
c. Female Genital Mutilation –
d. **Neglect**
e. **Voice of the Child**
f. Domestic violence
4. Participations and Engagement
a. **Voice of the Child**
b. **Engagement with Frontline Practice**
5. **Effectiveness of Multi-agency Practice**
6. Children's Workforce Development Issues

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SAFEGUARDING CHILD NEGLECT PROCEDURES AND TOOLKIT

Julie Quincey

Designated Nurse Safeguarding Adults and Children

Hosted Safeguarding Team CCG

Rama Ramakrishnan

Service Manager

NSPCC

THE VISION FOR LEICESTER, LEICESTERSHIRE AND RUTLAND

- Identifying neglect earlier within families, supporting parents to enable change through partnership working, in order to reduce the impact of neglect on the emotional and physical wellbeing of children.

RATIONALE

- This strategy has been developed in response to local knowledge on the causes and effects of neglect, learning from local serious case reviews (SCRs) and management case reviews within the LSCB areas and from the Ofsted Thematic Inspection report; ‘In the Child’s Time; Professional Responses to Neglect March 2014)’.

PURPOSE OF THE STRATEGY

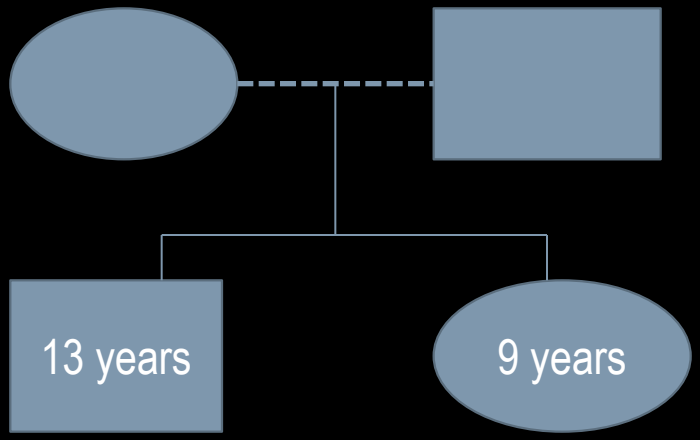
- The purpose of this strategy is to set out both LSCBs approach to tackling and reducing the impact of neglect on children across Leicester, Leicestershire and Rutland. This strategy also outlines the key principles that should underpin the work (and practice) around neglect in order to improve the collective partnership across LLR in response to tackling and reducing the impact of neglect.
- To secure collective commitment to addressing neglect across all partner agencies.
- To demonstrate effective leadership in driving changes in relation to system, culture and process changes within all agencies, both adults and children, working together to ensure that the needs of the child/ren are addressed.
- To improve awareness and a common understanding of neglect and the thresholds for intervention across the whole partnership, in order to ensure effective service provision.
- To improve the recognition, assessment (using appropriate tools) and response to children and young people living in neglectful situations before statutory intervention is required.

NEGLECT PROCEDURE

- The neglect procedure has been refreshed in line with learning from local and national serious case reviews
- Also in line with the Criminal law changes for neglect
- The procedure has been uploaded to the LSCB websites please see the link below
- The procedure includes a link to the new neglect toolkit which we will explore within this session

LESSONS FROM A LOCAL SILP

- The family structure



PARENTAL ISSUES WITHIN THE CASE

CHILD CONCERNS IN THE CASE

OVERVIEW FROM THE SILP STATED

- Assessments that the children could remain with their family were based on over optimism and did not take enough account of the chronology and listening to the voice of the children. Neither parent was capable of giving the Children the sort of family life they deserved. Even when residency orders were made the parents contradicted them and the Children were passed between them and respective grandparents as the Mother and Father saw fit and when it suited them.

CHILD PROTECTION PROCESSES

- The family were known to children's social services for seven years
- There were 7 Child Protection Conferences (2 Initials and 5 Reviews)
- Children were removed under a care order in 2013 due to chronic neglect

VOICE OF THE CHILD

- “When me and [Child 2] ran away from Dad’s the social kept taking us back. They did not listen when I told them that he was hurting us. They did not listen to Nan or Mum when they told them. The police just kept taking us back to him”.
- He added:
- “They should listen to Children more and take notice of what they say, then Children wouldn’t keep getting hurt”.

LESSONS TO BE DRAWN FROM THE CASE

- This case illustrates that workers throughout the seven years worked hard to address needs as they emerged
- The children lived between father's and mother's household as part of each child protection plan
- They was no systematic assessment of neglect
- No distance measured tool to assess whether the parents had the capacity to make meaningful change
- Thus the case drifted from one child protection plan to the next

AIMS OF THE REST OF THE SESSION

- To define neglect
- To explore assessment of neglect using the LSCB LLR neglect toolkit

DEFINITION OF NEGLECT

Working Together (2015) defines neglect as:

- “Neglect is the persistent failure to meet a child's basic physical and / or psychological needs, likely to result in the serious impairment of the child's health or development.
- Neglect may occur during pregnancy as a result of maternal substance abuse.
- Once a child is born, neglect may involve a parent or carer failing to:
- Provide adequate food, clothing and shelter (including exclusion from home or abandonment);
- Protect a child from physical and emotional harm or danger;
- Ensure adequate supervision (including the use of inadequate care-givers);
- Ensure access to appropriate medical care or treatment.
- It may also include neglect of, or unresponsiveness to, a child's basic emotional needs.”

THE CRIMINAL LAW AND NEGLECT

- From 3rd May 2015, the Serious Crime Act 2015 amends s.1 Children and Young Persons Act of 1933 (Child Cruelty) regarding neglect to read:
- “If any person who has attained the age of sixteen years and has responsibility for any Child or young person under that age, wilfully assaults, ill-treats (whether physically or otherwise), neglects, abandons, or exposes him, or causes or procures him to be assaulted, ill-treated (whether physically or otherwise),neglected, abandoned, or exposed, in a manner likely to cause him unnecessary suffering or injury to health (whether the suffering or injury is of a physical or psychological nature), that person shall be guilty of a an offence “

UNDERSTANDING NEGLECT

- Persistent
- Acts of omission or neglect
- Neglect often co-exists with other forms of abuse

PERSISTENT

- Ardo's partner Anwar has just started a two-year sentence in prison for possession and dealing of class A drugs. Ardo lives on her own with her four children aged 11, 9, 5 and 2. Ardo has become socially isolated from the Somali community and as a result has become depressed. Anwar before entering prison provided stability and was very active in their community which ensured the children had opportunities to socialise. The school where 11-year-old Abroon attends have noted he has been getting into fights and has recently been excluded. Abroon in the past has had behaviour difficulties when his father was estranged from the family.
- **Discuss with the person sitting next to you if you have a case example of your own that showed persistent neglect**

PERSISTENT

- Neglect is usually – but not always - something that is persistent, cumulative and occurs over time. It can continue without a critical event, or incidents may be widely spaced, but its effects are corrosive to children's development. Its presentation as a "chronic condition" requires the collation and analysis of sometimes small and seemingly insignificant events that only when viewed together provide evidence that neglect is an issue of concern.
- Neglect can also occur as a one-off event e.g. where there is a family crisis or a parent is under the influence of drink/drugs. It is possible that one-off incidents are part of a wider background of the neglect of the child, thus any incident based reports need to be assessed to identify whether there are patterns, however widely spaced.

ACTS OF OMISSION OR NEGLECT

- Samantha and Jack have three children under the age of five years, they regularly leave the children in the care of Jack's uncle. Jack's uncle Clive was convicted of a sexual offence against a child, this is known to both Samantha and Jack. Both parents now consider that Clive doesn't pose a risk to their children however they have no objective evidence to confirm this. The oldest child is noted by the nursery to be demonstrating sexualised behaviour inappropriate to a four-year old's developmental stage. Both Samantha and Jack have failed to take account of the risk that Clive poses to their children this is both an act of omission and commission.
- **In your twos can you think of a case where there has be omission**

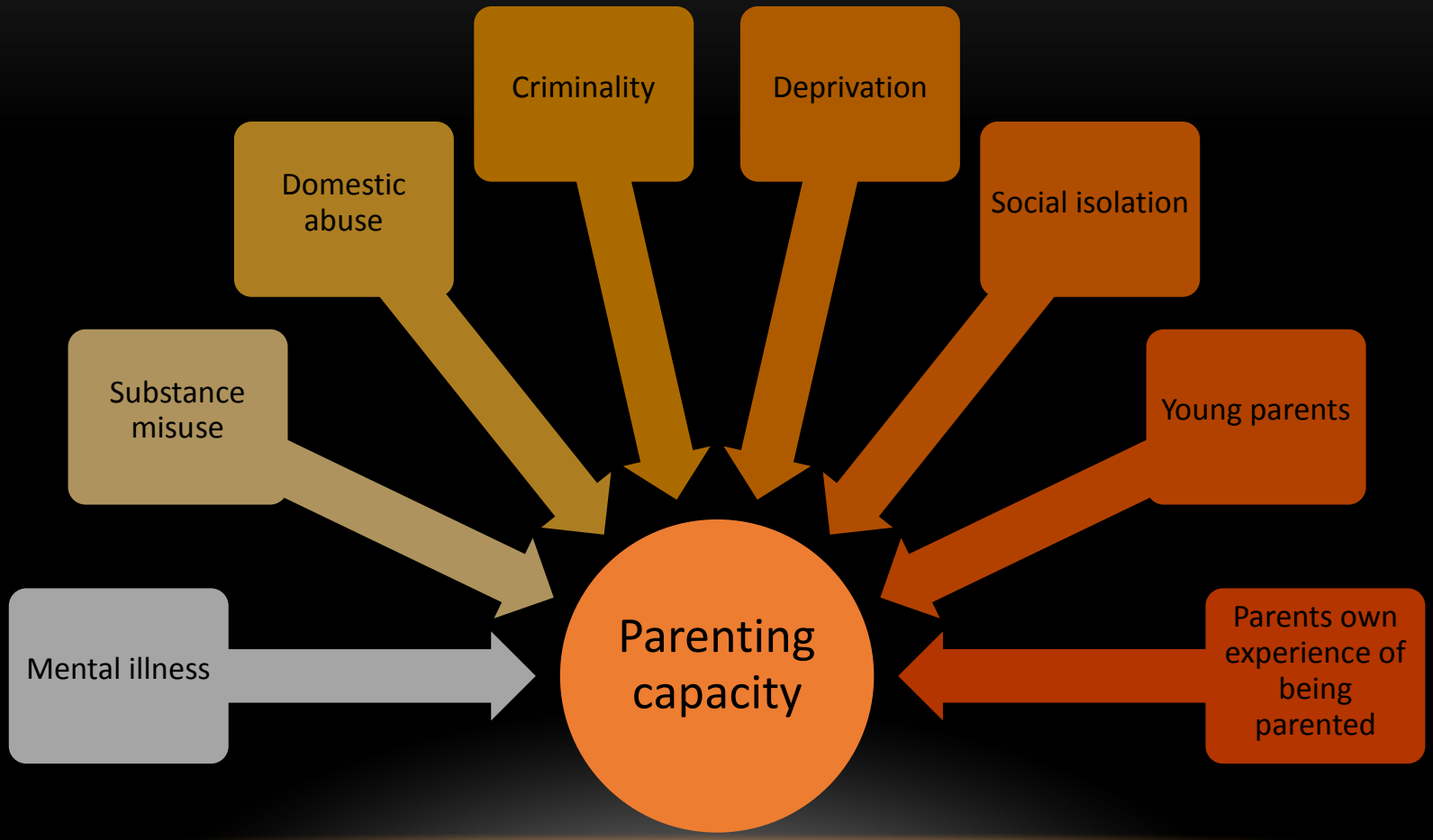
ACTS OF OMISSION OR NEGLECT

- Neglect is often – but not always - a passive form of abuse and the definition from 'Working Together, 2015, refers to 'failures' to undertake important parenting tasks, what is often referred to as 'acts of omission'. It is not always easy to distinguish between acts of omission and acts of commission and both can occur simultaneously. For example, a parent leaving a child in the supervision of an unsuitable person involves both an omission to provide appropriate supervision and intent in leaving the child with someone unsuitable. The issue for those identifying and assessing neglect is less about understanding intent and more about assessing the child's needs not being met. Neglect may be passive, but it is nevertheless harmful.

NEGLECT OFTEN CO-EXISTS WITH OTHER FORMS OF ABUSE:

- Certainly emotional abuse is a fundamental aspect of children's experiences of neglect. However other forms of harm such as physical abuse, sexual abuse, harm from exposure to domestic abuse, child sexual exploitation can and do co-exist with neglect. The existence of neglect should alert practitioners to exploring if children are being exposed to other forms of harm.

PARENTS AND CARERS WITH COMPLEX AND MULTIPLE NEEDS

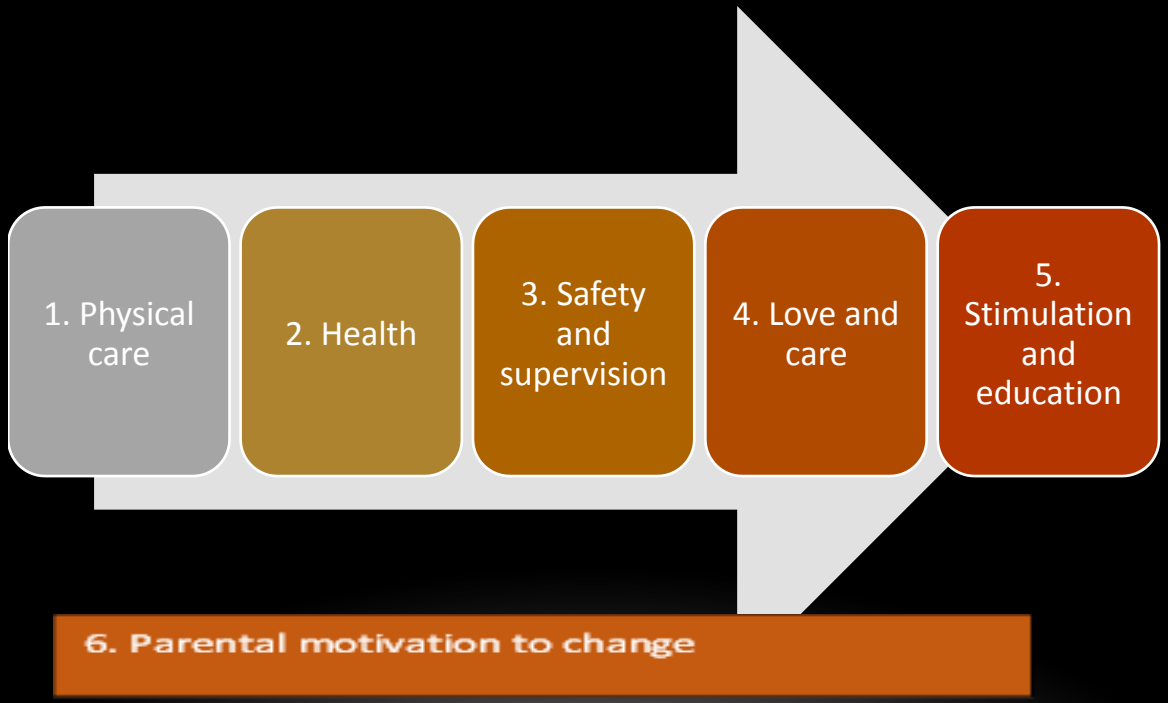


WHAT IS THE NEGLECT TOOLKIT

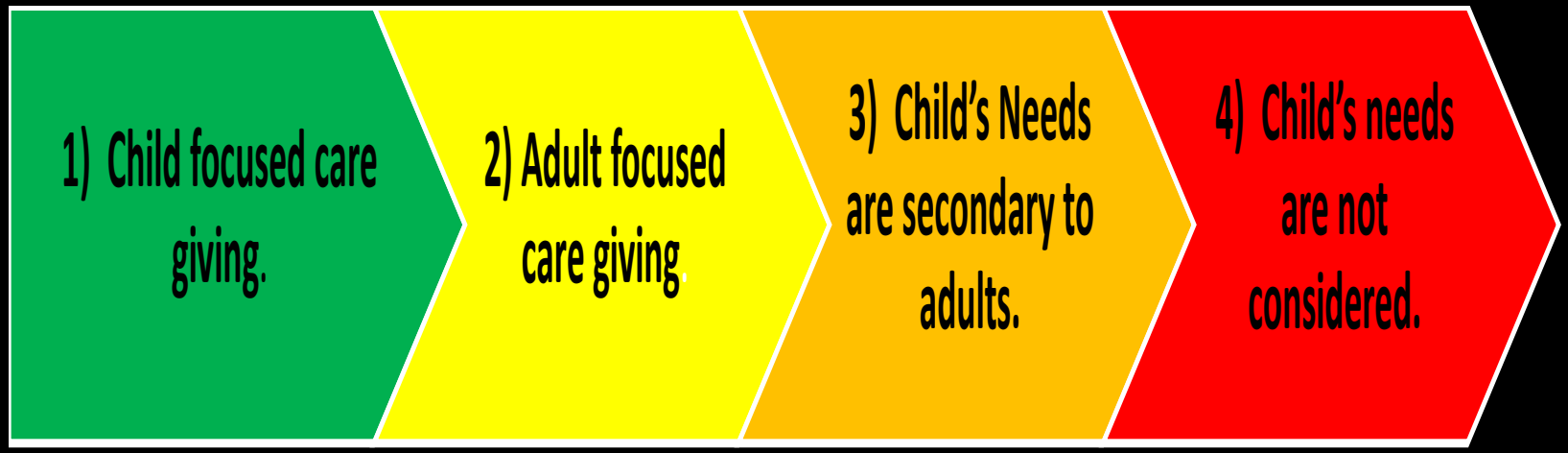
- The Neglect Toolkit is designed to assist you in identifying and assessing children who are at risk of neglect. It is to be used when you are concerned that the quality of care of a child you are working with suggests that their needs are being neglected. It will help you to reflect on the child's circumstances and will help you put your concerns into context and identify strengths and resources.
- The toolkit can be used as a distanced travelled tool, i.e. baseline at beginning of assessment and intervention, repeat the assessment at key parts of the intervention this could be as part of Early Help Assessment and team around the family meeting or in preparation for a core group. The baseline and subsequent scores of the toolkit can inform the practitioner if enough progress is being made and whether the parents/carers have the capacity to maintain this change.

THE FIVE AREAS

- The toolkit focuses on five key areas of need and considers the extent to which children's needs are being neglected and/or the needs of their parents/carers are taking precedence. The sixth dimension relates to the parental motivation to change.



HOW ITS SCORED



PARENTAL MOTIVATION TO CHANGE

THE SCORING SHEET

Developmental Need	Score				Examples/evidence of impact child/young person
AREA 1: PHYSICAL CARE	1	2	3	4	
Food					
Quality of housing					
Stability of housing					
Child's clothing					
Animals					
Hygiene					
AREA 2: HEALTH	1	2	3	4	
Safe sleeping arrangements and co-sleeping for babies					
Seeking advice and intervention					
Disability and illness					
AREA 3: Safety and supervision	1	2	3	4	
Safety awareness and features					
Supervision of the child					
Handling of baby/response to baby					
Care by other adults					
Responding to adolescents					
Traffic awareness and in car safety					
AREA 4: Love and care	1	2	3	4	
Parents/carers attitude to child, warmth and care					
Boundaries					
Adult arguments and violence					
Young carers					
Positive values					
Adult behaviour					
Substance misuse					
AREA 5: STIMULATION AND EDUCATION	1	2	3	4	
Unborn					
0-2					
2-5					
school					
Sport and leisure					
Friendships					
Addressing bullying					
PARENTAL MOTIVATION FOR CHANGE	1	2	3	4	
TOTAL IN EACH AREA					

What actions are to be taken as a result of completing this checklist?

Date Completed	
Name of Assessor	
Name of Assessor	
Name of Manager	

THE TOOLKIT AND YOUR ASSESSMENT

- By working through the toolkit and scoring individual sections you will be able to identify strengths as well as areas of concern that will underpin any full assessment you may use within your service.
- Where there are areas scored 3 and 4 these are cause for concern and should be discussed with your line manager as soon as possible. In discussion with your manager, depending on which areas are highlighted, weighting should be applied in relation to the context for the family.
- The needs of children and young people and their families need to be considered on a case by case basis. Responses should be based on robust assessment, sound professional judgment and where appropriate statutory guidance.
- It is also incumbent on practitioners to take account of the available resources, local priorities and policy guidance.

ON YOUR TABLES

- You will find one example of each care domain that uses the themes from the SILP already discussed
- Can you examine the matrix and think how you may have assessed the SILP family

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Multi- Agency Safeguarding Practitioner Sub Group

Chair: Janice Brien

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Managing allegations against adults who work with children

Presentation by

Steve Tee, LADO - City

Elaine Newcombe - Service Manager, Rutland

Mark Goddard, LADO - County

Contact details

- City – Allegation Duty Manager
- 0116 454 2440
- Rutland – Elaine Newcombe or Steve Tanner – 01572 758446
- County – Mark Goddard or Karen Browne - 0116 305 7597

Role of LADO

- Local authorities are required to designate officers to be involved in the management and oversight of individual cases
- provide advice and guidance to employers and voluntary organisations around thresholds of harm and unsuitability
- liaise with the police, social care and other organisations as needed
- ensure a consistent, fair and thorough process for the child and adult

Local arrangements

- Section 3.9 of LSCB procedures sets out local guidelines and is designed to ensure that if an allegation of harm is made, or there is any suspicion of harm, appropriate enquiries are made to protect children and maintain public confidence in services.

When to use the procedure

The procedure should be used if it has been alleged that member of staff, foster carer or volunteer has

- behaved in a way that has harmed a child, or may have harmed a child
- possibly committed a criminal offence against or related to a child; or
- behaved towards a child or children in a way that indicates s/he may be a risk to children in the workplace

When to contact the LADO

This applies when the allegation or concern arises in the following circumstances

- Within the adult's own work setting
- Own children make allegations
- Other children living outside the family
- historical allegations

Responding to allegations or concerns

- All allegations against members of staff, paid or unpaid and foster carers must be taken seriously and acted upon
- Allegations and concerns about the behaviour of an adult should be reported to the senior manager in the organisation immediately
- It is important to ensure that even apparently less serious allegations are seen to be followed up, and they are examined objectively by someone independent of the organisation concerned

Initial discussion with LADO

- All allegations of harm must be notified to the LADO within 24 hours
- The purpose of the initial discussion is for the LADO and the senior manager to consider the nature, content and context of the allegation
- Advice and guidance will be provided by the LADO about thresholds and a course of action agreed

Outcome of initial discussion

- If thresholds for harm are not met but there is sufficient concern about the adult's behaviour then a meeting will be arranged to evaluate the concern
- Other areas of concern around conduct and behaviour can be dealt with through internal procedures
- If threshold for harm or risk of harm is met the allegation will be referred to Police and Children's Social Care and a strategy meeting arranged

Agreeing next actions

- If threshold for harm/risky behaviour is met then Employer/Manager will undertake risk assessment and consider interim safeguarding arrangements
- Seek advice from HR and suspension to be considered
- Collect relevant information, statements from other staff/children/witnesses
- Record factual account of allegation and initiate chronology of events
- Complete internal procedures and notifications to regulatory bodies

Investigation of allegation

- As stated It is the duty of Children's Social Care to undertake joint enquires with the Police to investigate all allegations of harm or suspicion of harm and complete an initial assessment of need
- Police enquires will establish if a crime has been committed and present a case to Crown Prosecution Service (CPS)
- An internal/disciplinary investigation to run alongside Children's Social Care and Police enquiries when agreed
- The outcome of these enquiries will be considered in a multi agency strategy meeting

Who attends strategy meeting

- Employer/Senior Manager /Committee member
- Chair of Governors
- Human Resources representative
- Police
- Social Care Investigation Officer
- Team Manager /Social Worker for child
- Fostering Team Manager/Supervising Social Worker
- Medical examiner

Role and function of the strategy meeting discussion

- Strategy discussion should take the form of a face to face meeting wherever possible in order to share all relevant information about the allegation and investigation
- Discuss any previous allegation or concern
- Share relevant information about the child and adult
- Review the interim safeguarding arrangements
- Plan further action, including any internal enquires, allocate tasks, set timescales

Role and function of the strategy meeting discussion (Continued)

- Consider what advice and support should be made available to employee, foster carer and child/family
- Consider any factors that may affect the management of the case, confidentiality, media interest, vulnerability of the adult and child.
- If the adult's behaviour does not require investigation by Children's Social Care /Police then a similar meeting can be held between the LADO and employer to jointly evaluate the level of concern and agree a course of action which may include disciplinary action

Outcome strategy meeting

- A multi-agency strategy meeting will discuss the outcome of enquiries and consider the level of risk posed in the work setting and whether the person's suitability to continue working with children in current position has been called into question
- Where suitability to work with children is called into question a recommendation will be made by this meeting to the employer to consider disciplinary action
- Employee to be advised of outcome and any action
- If appropriate, consider return to work arrangements
- Consider any lessons learnt and action required
- Child and parents should be provided with relevant information about the final outcome

Outcome of strategy meeting

- Unfounded
- Unsubstantiated
- Substantiated
- False
- Malicious

Employer's actions

- Further action by the employer will always be required in circumstances where a multi agency meeting has concluded that disciplinary action should be considered by the employer
- The recorded views of the LADO and other professionals consulted as part of the strategy discussion should be taken into account
- At the conclusion of the disciplinary investigation the employer must form a view about grounds under which the behaviour of the adult should be considered in a disciplinary hearing

Employer's actions
(continued)

- The disciplinary panel must have regard to all the evidence presented to them and decide on the balance of probability :-
- whether the person's behaviour has posed or could pose a risk to children to whom the organisation owes a duty of care
- whether the behaviour has compromised, or could be seen to have compromised, the ability and reputation of the organisation to safeguard children by any failure to uphold the standards expected of the employee

Employer's actions
(continued)

- Where employers have ceased to use a person's services for reasons of Child Protection or Safeguarding they are required to make a referral to Disclosure and Barring Service (DBS) who will make the final barring decision
- Employers in Local Authority Children's Services have a statutory duty to make a referral if they cease to use the person's services
- Employers will also make referral to appropriate regulatory body
- Employers will inform the LADO of the conclusion of the disciplinary process in all cases

Why do allegations arise?

- Poor safeguarding culture in organisation
- Failure to follow procedures
- Naivety and poor practice
- Use of unnecessary and inappropriate restraint
- False allegation/misinterpretation of behaviour
- Deliberate intention to harm a child
- Criminal behaviour
- Abuse via digital technology

Safer working practices

- Ensure staff are aware of all policy and procedures within organisation
- Ensure staff are aware of expectations of their conduct and behaviour
- Develop safeguarding and code of conduct policy
- Ensure behaviour management and restraint procedures are understood
- Ensure organisation has clear E safety guidelines in place

Key Messages

- Management of allegations sits within an effective cycle of good practice
- Robust systems for dealing with allegations reduces harm
- Provides an open and transparent system that is fair to all
- Supports development of a safer workforce

Key Messages

- Children must be listened to and heard
- All allegations must be taken seriously, not pre judged and acted upon
- All allegations that meet criteria must be reported to LADO in 24 hours
- Police and Social care will investigate where appropriate
- Most allegations are resolved through internal processes with favourable outcome

Vulnerability & Risks to Babies

Dr Sethi & Jan Harrison

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Evaluation forms & Certificates

Leicestershire & Rutland Procedures:

http://llrscb.proceduresonline.com/index.htm

Leicestershire & Rutland:
http://lrsb.org.uk/

Leicester City:
http://www.lcitylscb.org/

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