Leicester, Leicestershire & Rutland LSCB Multi-agency Neglect Toolkit Survey and Audit: Summary Briefing

This summary briefing presents the key findings/recommendations from the LLR LSCB neglect toolkit survey and audit and is aimed at managers and practitioners working with children and families in Leicester, Leicestershire and Rutland. Please share this briefing with colleagues.

Background

- The issue of neglect was a priority for both LSCBs in 2015-2016 and has featured in national and local serious case reviews/learning reviews, resulting in the development of the LLR neglect strategy, toolkit and review of the neglect procedure. Following the launch of the neglect toolkit on 7th July 2016 a LLR online survey on the use and impact of the toolkit was conducted between October 2016-January 2017 and a deep dive audit was completed in April 2017.
- Working Together to Safeguard Children (2015) requires Local safeguarding Children Boards to evaluate multi-agency working through joint audits of case files.
- The key findings from the survey and audit were reported to the LLR LSCB Joint Executive Group and the relevant sub-groups of both LSCBs.
- The key messages from both the online survey and neglect audit have been put together and presented in this summary briefing.

Methodology

LLR online neglect survey: practitioners who attended the LLR neglect Toolkit launch event on 7th July 2016 were asked to indicate if they were interested in participating in the online survey. These participants as well as safeguarding leads for both the LSCBs and representatives of the LLR LSCBs neglect reference group were contacted via e-mail to enlist practitioners within their services/agencies to participate in the survey.

Thirty nine surveys were fully completed out of the 61 responses received. Those that were not completed contained useful information.

LLR multiagency deep dive audit: ten cases were audited (4 for Leicester; 4 for Leicestershire and 2 for Rutland). The cases were selected for auditing by the LSCBs from the cases identified by the 3 local authorities Children's Services. The scope was 1st July-31st January 2017.

Definition of neglect

According to Working Together 2015 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 carers 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); or*
- *ensure access to appropriate medical care or treatment.*

It may also include neglect of, or unresponsiveness to, a child's basic emotional needs".

*In addition to the above, the LLR LSCB definition includes: *'or failing to receive appropriate antenatal care'.*

Section 1 of the Children and Young Persons Act 1933 (Child Cruelty), as amended by the Serious Crime Act 2015, also impacts on Neglect:

"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 (including injury to or loss of sight, or hearing, or limb, or organ of the body, and any mental derangement) (whether the suffering or injury is of a physical or psychological nature), that person shall be guilty of an offence"

Further Information

LSCB Website | LLR LSCB Multi-agency Safeguarding procedures | LSCB multiagency audit summaries | LLR LSCB Neglect Toolkit

L&RSB Website | LLR Resolving Practitioner Disagreements and Escalation of Concerns

What practitioners and parents/carers said about the toolkit:

Where the toolkit had been used it was found to be useful in evidencing assessments and in explaining neglect to parents and what they need to do, as illustrated by the following quotes:

- *Used in professional meeting with nursery and SLF worker to join up thinking and process to outcome.*
- *Using the toolkit allowed me to have objective assessment of key areas of neglect including emotional neglect and home conditions. It supported my referral to social care and discussion with CCG named nurse and LPT named nurse and Doctors.*
- *I used the toolkit to formalise my thinking around an issue that was going on with a child regarding eating and parent's ability to provide regular, nutritious food, at times and in formats suitable for a child of his age. It fitted into the yellow/amber areas of the kit but, as it was already being monitored by health and myself, we didn't need to take it any further.*
- *I manage an early help team within children's services and this tool has supported myself and staff to provide evidence to parents who themselves have suffered neglect and been unable to identify their children are now suffering neglect. This has allowed us to challenge and show concerns, which, in turn has allowed them to access support from us and other services to change their situation.*
- *It showed us areas where things needed to be improved and identified areas where things were better within the home*
- *We were able at a home visit with social workers and an early intervention health visitor to identify the areas of risk that I was concerned about – factual scores that support holistic assessment and need for early and timely intervention.*
- *Although not used in its entirety, it definitely helped this parent to improve in the areas needed and this child gained weight and got back on track with his development.*
- *We cleaned up our act (parent)*

Key Findings and recommendations

1. The online survey and deep dive audit found that the neglect toolkit has not been embedded and therefore used in practice as well as expected within agencies across LLR (in the deep dive audit the toolkit was used in only 2 out of the 10 cases audited). Partner agencies should ensure that professionals and practitioners within their agencies use, and embed fully in routine practice the LLR LSCB Neglect Toolkit to inform assessments and reviews, as the neglect tool kit helps with analysis and understanding of the case.

2. The deep dive audit identified that there was evidence of drift in majority of the cases. This was of particular concern as most elements in the neglect cases audited were of a lower level and there appeared to be little grip around the case, allowing neglect to become prolonged and in some families it started to become normalised behaviour. It is recommended that case management should be improved through regular reviews and robust supervision of cases.

3. The voice of the child was obtained in some cases, but not in all of the deep dive cases audited. In some cases the children were not spoken to alone. This should be routine practice, and where a child is too young then they should be observed and interactions recorded. Partner agencies should embed obtaining the voice of the child into all practice.

4. Multi-agency information sharing was inconsistent and administration around Child Protection Conferences and Core group meetings needs improving. Partner agencies should ensure that information sharing is taking place and Children Social Care should ensure that sufficient notice is given to practitioners for Child Protection Conferences and multi-agency Core group meetings and that practitioners are informed of Child Protection Plans.

5. The online survey found that practitioners were aware of Escalation procedures. However, the deep dive audit found that escalation was taking place, but there was a need for escalating concerns in a timely way and to be more robust. There seemed to be a nervousness or lack of knowledge or confidence amongst practitioners to challenge decisions affecting children's safety. Partner agencies should raise awareness of and encourage use of the LLR Resolving Practitioner Disagreements and Escalation of Concerns procedures within their agencies.

6. As the neglect toolkit is still being embedded it is too soon to evaluate the impact of the toolkit and also obtain the views of children regarding difference made to them. Another survey conducted in 6 months times should provide further information on how well the toolkit has been embedded and the impact on making a difference to children and families.