HULL
Safeguarding Children Board

# Children Living With Neglect – Learning From Practice (Joint Evaluations & CSC Audits) v.02

## Why did we carry out practice audits on cases where children are living with neglect?

Neglect is a risk factor in 60% of all Serious Case Reviews and is the most common reason nationally for taking child protection action. Neglect featured prominently in a recent local serious case review. 'Children living with neglect' is also the 'deep dive' theme for the Joint Targeted Area Inspection between May-Dec 2017 and is an HSCB priority. We wanted to learn from a wider sample of cases in order to identify strengths and areas for development. We initially jointly evaluated 6 neglect cases and a further 21 were subject of a CSC single agency audit. Between Oct – Dec 2017 we jointly evaluated a further nine cases which were identified as featuring neglect.

**Strengths**

- Evidence from assessments and case notes that social workers, and pods, know children and families well
- Evidence of good communication between agencies in most cases – regular, well-attended core groups and conferences.
- Examples of assessments which carefully considered the individual needs of each child and recorded good information-gathering from partner agencies.
- Records from across agencies generally reflected a consistent history of multi-agency working.
- Evidence of progress in most cases which had led to improvements in the lives of children.
- One assessment in particular demonstrated a good understanding of the cumulative impact of neglect for both children.
- An example of a SMART CP plan which described a strong multi-agency plan of action.
- Decision-making in relation to the most recent concerns appeared sound and appropriate.
- Examples of good quality referrals from Police & NPS – including a high quality Police DA '913' which recorded the views of the child.
- Examples of really positive and effective joint working between schools and locality social workers
- Feedback from one school that the new EHASH arrangements had helped to improve communication with CSC.

**Areas for Development**

- There was no evidence of the use of evidence-based neglect tools to inform assessments & work with families
- Children's plans were seldom SMART – often lists of actions, with lack of clarity about what needs to change and timescales.
- In many cases there was some evidence of 'drift and delay' – e.g. repeated episodes of CSC involvement, short-term improvement & re-referral and delay in bringing cases to ICPC and/or PLO
- The recording available to auditors did not always reflect the work actually undertaken
- Cases evidenced regular core groups but it was not always clear how purposeful these were and records of meetings were not always available.
- There was no evidence of health involvement in strategy discussions in the majority of cases.
- Maternal mental health issues were referenced in many cases but with little evidence that these issues were explored further as part of ongoing work.
- In some cases the role of men and fathers could have been more fully assessed and considered.
- Chronologies were not readily available to help identify historical factors/patterns
- Cases showed inconsistent engagement and communication with GP's

**What is being done to strengthen our work on 'neglect' across the partnership?**

- Evidence-based tools to help practitioners recognise neglect and assess its impact have been locally developed and tested and are now being used across the partnership
- Revised HSCB neglect training has been developed. This is designed to help practitioners use the new tools and develop a deeper understanding of neglect and its impact on children. Training on the use of the new tools is 'live' – impact training is being piloted in January 2018
- Work is planned on producing some guidance on 'good' children's plans.
- The Board has developed a neglect strategy which will be launched in Feb/March 2018.
- Work is being undertaken to better understand the extent and nature of neglect in Hull and how to measure improvement.
- Work is continuing to strengthen engagement with men and fathers across services and in all contexts.
- Materials have been developed and circulated to help agencies disseminate the learning from the recent local serious case review.
- A simple 'Think GP' guide is being produced to help strengthen engagement with GP's.
- Work has been undertaken with CPC chairs to ensure that, where neglect is the main concern for a child's safety, that this is 'named' and reflected in CP categorisation.

**Issues for practitioners to consider:**

- Beware of 'over-optimism' and placing too much emphasis on short-term change – carefully assess parental capacity to make and sustain change in the long-term
- Clearly identify what neglect is for each child and its impact on them. This is essential so that families and professionals are clear about what needs to change and how change will be measured.
- Ensure that historical information is available and fully considered.