

# In the child's time: professional responses to neglect

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The report explores the effectiveness of arrangements to safeguard children who experience neglect, with a particular focus on children aged 10 years and under. The report draws on evidence from 124 cases and from the views of parents, carers and professionals from the local authority and partner agencies.

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## Executive summary

The findings from this thematic inspection present a mixed picture in respect of the quality of professional responses to neglect. Examples of good practice were identified and in some local authorities professionals have a range of methods and approaches to working with neglect that are making a positive difference for children. However, the quality of professional practice was found to be too variable overall, with the result that some children are left in situations of neglect for too long.

One third of long-term cases examined on this inspection were characterised by drift and delay, resulting in failure to protect children from continued neglect and poor planning in respect of their needs and future care. No children however were found to be at immediate risk of harm at the time of the inspection.

A range of assessment methods are being used in local authorities to work with families where children are neglected. Some of these have a clear evidence base, are highly valued by professionals and enable direct work with families to support strong assessments. There are also some good examples of professionals using a range of indicators to track and monitor the impact of interventions and to measure progress when children are subject to child protection plans. However, such methods are not used in all authorities and the quality of assessments in neglect cases overall was found to be too variable. Almost half of assessments seen either did not take sufficient account of the family history or did not sufficiently convey or consider the impact of neglect on the child. It is imperative therefore that there is learning from good practice to drive improvement in the quality of assessments, planning and the management of risk for children who are neglected.

The practice of engaging parents in child in need and child protection work was found to be a significant challenge to professionals. Parents are likely to have multiple and complex needs of their own and may be very demanding of social work time and attention. In those cases where children were not making positive progress, a common feature was parental lack of engagement. However, only a few multi-agency groups that were involved in child protection planning demonstrated clear strategies for tackling non-compliance.

Most professionals have access to some training on the theme of neglect, yet there is little effective evaluation of its impact, and on this inspection, in many cases seen, the training did not improve the quality of professional practice or the experiences of the children. There is a wealth of research about neglect, but practitioners have limited time to access this knowledge. There was little evidence of the application of specific research to practice.

Local areas visited had difficulty in identifying the prevalence of children in receipt of services for neglect. This is of significant concern. The number of children subject to child protection plans in the category of neglect was known, but will be an underestimation of the extent of neglect. There will be children who are not yet in receipt of a statutory child protection service but who are being offered earlier help

and those whose need or protection plans address other more obvious concerns, such as physical abuse who may also be suffering from neglect. Local Safeguarding Children Boards (LSCBs) did not always fully understand the local prevalence of neglect, and this makes it significantly more challenging to evaluate the effectiveness of multi-agency plans to prioritise and respond to neglect.

Some local authorities can and do make a positive difference to the lives of many children living in situations of neglect. Those local authorities providing the strongest evidence of the most comprehensive action to tackle neglect were more likely to have a neglect strategy and/or a systematic improvement programme addressing policy, thresholds for action and professional practice at the front line.

Urgent and decisive action is needed to address the issues highlighted in this inspection and to drive improvements in practice. The challenge for local authorities and partner agencies is to learn lessons from those cases where professional responses to neglect are timely and effective, thereby providing families with the help they need. Social work professionals in particular must improve the quality of their engagement with, and assessment of families where children are neglected. The cumulative and pervasive impact of neglect on the development of children and their life chances has to be properly addressed if they are to be able to contribute to, and benefit from society as adults and future parents.

## Key findings

- The quality of professional practice in cases of neglect overall was found to be too variable, although in some of the cases examined at this inspection, children were making progress.
- Nearly half of assessments in the cases seen either did not take sufficient account of the family history, or did not adequately convey or consider the impact of neglect on the child. Some assessments focused almost exclusively on the parents' needs rather than analysing the impact of adult behaviours on children. In a small number of cases this delayed the action local agencies took to protect children from suffering further harm.
- While the quality of written plans was found to be too variable, there was evidence of some very good support for children that was meeting the short-term needs of the family. However, there was very little evidence of longer-term support being provided to enable sustained change in the care given to the children.
- Some authorities are using effective methods to map and measure the impact of neglect on children over time and to evaluate the effectiveness of interventions. This results in timely and improved decision-making in some cases. However, not all local authorities have such systems in place to support social workers in monitoring the impact of neglect on children and the effectiveness of their interventions.

- Non-compliance and disguised compliance by parents were common features in cases reviewed. Although some multi-agency groups adopted clear strategies to manage such behaviour, this was not evident in all cases. Where parents were not engaging with plans, and outcomes for children were not improving, professionals did not consistently challenge parents.
- Drift was identified at some stage in the child’s journey in a third of all long-term cases examined, delaying appropriate action to meet the needs of children and to protect them from further harm. Drift was caused by a range of factors, including inadequate assessments, poor planning, parents failing to engage and in a small number of cases, lack of understanding by professionals of the cumulative impact of neglect on children’s health and development. Drift and delay have serious consequences for children, resulting in them continuing to be exposed to neglect.
- Front-line social workers and managers have access to research findings in relation to neglect, although the extent to which this is incorporated into practice varies. It is by exception that front-line social workers use specific research to support their work. The impact of training on professional practice with regard to neglect is neither systematically evident nor routinely evaluated.
- Routine performance monitoring and reporting arrangements to LSCBs infrequently profile neglect. Therefore most boards do not receive or collect neglect data except in respect of the number of child protection plans where the category is recorded as neglect. Most boards were not able to provide robust evidence of their evaluation and challenge about the effectiveness of multi-agency working to tackle neglect.
- Those local authorities providing the strongest evidence of the most comprehensive action to tackle neglect were more likely to have a neglect strategy and/or a systematic improvement programme across policy and practice, involving the development of specific approaches to neglect.
- The challenge for local authorities and their partners is to ensure that best practice in cases of neglect is shared in order to drive improvement.

## Recommendations

The government should:

- review the social work reform programme and ensure that training, both before and after qualification, includes mandatory material on neglect, focusing on its identification and assessment, as well as comprehensive training on child development, attachment theory and child observation
- require (through revised regulations) that all LSCBs develop a multi-agency strategy to increase their local understanding of the prevalence of neglect and to improve the identification of, and responses to neglect.

LSCBs should:

- have access to and regularly examine data and quality assurance information to enable them to monitor the quality of practice in relation to neglect across early help, child in need and child protection interventions
- ensure that all agencies, including adult mental health services; drug and alcohol services; police and social work services working with families where there is domestic abuse; and services for adults with learning difficulties, work effectively together to assess and agree plans for children who experience neglect
- ensure that practitioners and their managers have access to high-quality specialist training on the recognition and management of parental non-compliance and disguised compliance
- ensure that the training provided for front-line practitioners and managers enables access to contemporary research and best practice in working with neglect
- ensure that all staff are aware of their duty to escalate concerns when they consider that a child is not appropriately protected and/or is suffering from neglect, and that all agencies have appropriate escalation policies and procedures, including a procedure for challenging the decisions of children's social care services where cases are not accepted for assessment or child protection investigation.

Local authorities should:

- ensure that there is robust management oversight of neglect cases, so that drift and delay are identified and there is intervention to protect children where the risk of harm or actual harm, remains or intensifies.
- prioritise the training and development of front-line practitioners, focusing on the skills needed to engage in direct work with families and the development of good assessments that describe what life at home is like for children.
- support social workers and managers in the use of models and methods of assessment that enable them to effectively describe and analyse all risk factors in cases of neglect and then take decisive action where this is required
- prioritise the development and use of plans to support and protect children suffering from neglect, ensure that those plans set out clearly, with timescales, what needs to change and the consequences of no or limited change; plans should be subject to routine management oversight given the complexity of work with neglected children.
- ensure that social workers have specialist training and supervision to enable them to exercise professional authority and challenge parents who fail to engage with services, particularly when their children are subject to child

protection plans; this process should be subject to robust, regular management oversight and practice audit

- ensure that there is clarity about the threshold for care proceedings to be initiated in cases of neglect, and that the threshold is understood, consistently applied and monitored by local authority social care staff, senior managers and their legal advisers
- oversee the written evidence presented to courts so that it is clear, concise and explicitly describes the cumulative impact of neglect on the daily life of the child.

## Introduction

1. There is now a considerable body of research which demonstrates the damage done to young children living in situations of neglect; this includes the impact of a lack of stimulation, resulting in delayed speech and language, and the development of insecure attachments. The pervasive and long-term cumulative impact of neglect on the well-being of children of all ages is also well documented. All aspects of children's development can be, and are, adversely affected by neglect, including physical and cognitive development, emotional and social well-being and children's mental health and behaviour.<sup>1,2</sup> For some children the consequences of neglect are fatal. The need to take decisive and timely action to protect children is supported by a wide range of research. Yet serious case reviews continue to provide us with evidence that for professionals working with children, young people and families this is one of the most challenging areas of their work.
2. The recognition of neglect and the action taken by local authorities and others to prevent children suffering from neglect is of particular interest to the government. The Education Select Committee reviewed the child protection system in 2012.<sup>3</sup> They concluded that the needs of children and the importance of acting quickly to secure early intervention for children are all too often not given enough priority. This view was echoed in the speeches by the Secretary of State in November 2012 and November 2013.<sup>4</sup>

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<sup>1</sup> C Davies and H Ward, *Safeguarding children across services: messages from research*, Department for Education, 2011; [www.gov.uk/government/publications/safeguarding-children-across-services-messages-from-research](http://www.gov.uk/government/publications/safeguarding-children-across-services-messages-from-research).

<sup>2</sup> A Lazenbatt, *The impact of abuse and neglect on the health and mental health of children and young people*, NSPCC Research briefing, 2010; [www.nspcc.org.uk/Inform/research/briefings/impact\\_of\\_abuse\\_on\\_health\\_wda73372.html](http://www.nspcc.org.uk/Inform/research/briefings/impact_of_abuse_on_health_wda73372.html).

<sup>3</sup> *Children first: the child protection system in England*, 2012; [www.publications.parliament.uk/pa/cm201213/cmselect/cmeduc/137/13702.htm](http://www.publications.parliament.uk/pa/cm201213/cmselect/cmeduc/137/13702.htm).

<sup>4</sup> 'The failure of child protection and the need for a fresh start', Michael Gove's speech to the Institute of Public Policy Research (IPPR), 16 November 2012, Department for Education, 2012; [www.gov.uk/government/speeches/the-failure-of-child-protection-and-the-need-for-a-fresh-start](http://www.gov.uk/government/speeches/the-failure-of-child-protection-and-the-need-for-a-fresh-start).



3. The current economic and social climate, however, is very challenging for families and for those professionals working with children who may experience neglect. Recent National Society for the Prevention of Cruelty to Children (NSPCC) research identified that 'child protection services are working in overdrive' as a result of increasing numbers of referrals over recent years.<sup>5</sup> Children who are referred are more likely to receive assessments or be subject to further action compared with five years ago, resulting in increased activity in child protection services. At the same time local authorities are facing pressures from a significant reduction in funding and increased levels of poverty and deprivation. Data from the Institute for Fiscal Studies on the central funding allocation to local government show a 26.6% reduction in local authority budgets in the five years since 2010.<sup>6</sup> A recent report commissioned by three leading children's charities projected that the number of children living in extremely vulnerable families is set to almost double by 2015.<sup>7</sup> The combination of factors set out in the report that define extremely vulnerable families are those that increase the likelihood of neglect, such as maternal mental health difficulties, material deprivation, poor-quality housing, and parental illness.
  
4. *Working together to safeguard children*<sup>8</sup> describes neglect as:
 

'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 or 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 caregivers); ensure access to appropriate medical care or treatment. It may also include neglect of, or unresponsiveness to, a child's basic emotional needs.'
  
5. Determining what constitutes a 'persistent failure', or 'adequate clothing' or 'adequate supervision' remains a matter of professional judgement. Even when professionals have concerns about neglect, research indicates that they may be unlikely to consider how they can help or intervene, apart from referring to

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<sup>5</sup> L Harker et al, *How safe are our children?*, NSPCC, 2013; [www.nspcc.org.uk/inform/research/findings/how-safe/how-safe-2013\\_wda95178.html](http://www.nspcc.org.uk/inform/research/findings/how-safe/how-safe-2013_wda95178.html).

<sup>6</sup> *The squeeze continues*, Institute for Fiscal Studies, June 2013; [www.ifs.org.uk/publications/6740](http://www.ifs.org.uk/publications/6740).

<sup>7</sup> H Reed, *In the eye of the storm; Britain's forgotten children and families*, Action for Children, 2012; [www.actionforchildren.org.uk/policy-research/policy-priorities/in-the-eye-of-the-storm-britains-forgotten-children-and-families](http://www.actionforchildren.org.uk/policy-research/policy-priorities/in-the-eye-of-the-storm-britains-forgotten-children-and-families).

<sup>8</sup> *Working together to safeguard children*, Department for Education, 2013; [www.education.gov.uk/about/dfes/statutory/g00213160/working-together-to-safeguard-children](http://www.education.gov.uk/about/dfes/statutory/g00213160/working-together-to-safeguard-children).

children's social care.<sup>9</sup> Research also suggests that social workers may operate to a higher threshold than the general public, in part because they become desensitised to children's poor living conditions and, in consequence, lower their expectations of what constitutes good enough parenting.<sup>10</sup> Three recent studies of social work intervention found extensive evidence of thresholds for access to children's social care being too high and of professionals giving parents 'too many chances' to demonstrate that they could look after a child; often in the face of substantial evidence to the contrary and regardless of the needs of the child.<sup>11</sup>

6. Ofsted inspections of safeguarding and child protection frequently highlight deficits in the quality of assessments: in particular the failure to take account of parents' and children's previous history, the often poor quality of analysis of risks and a lack of understanding of the impact of the concerns on the child. A decline in the time that social workers spend working with families directly, a finding made in the Munro Review of 2011, also reduces the opportunity for social workers to directly assess and analyse the quality of parenting for children and young people. Research highlights the importance of early recognition and prompt intervention in a child's life. The impact of emotional abuse and neglect can be particularly severe when it occurs during early childhood, because the first three years of life are so critical to children's later development.<sup>12</sup>
7. Research also indicates that social workers' knowledge of child development is not always well-developed and as a result they are less likely to understand the impact of neglect on children and the importance of timely decision-making to avoid significant harm.<sup>13</sup> All these factors contribute to neglect not being well-recognised and its impact not well-understood.
8. The incidence of neglect is hard to quantify but the recent review of neglect by Action for Children, highlighted professional belief that the number of neglected

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<sup>9</sup> B Daniel, J Taylor, J Scott, *Noticing and helping the neglected child; literature review*, Report to Department for Children, Schools and Families, University of Stirling, 2009; [www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/189593/DCSF-RBX-09-03.pdf](http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/189593/DCSF-RBX-09-03.pdf).

<sup>10</sup> B Daniel, J Taylor, J Scott, *Noticing and helping the neglected child; literature review*, Report to Department for Children, Schools and Families, University of Stirling, 2009; [www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/189593/DCSF-RBX-09-03.pdf](http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/189593/DCSF-RBX-09-03.pdf).

<sup>11</sup> C Davies and H Ward, *Safeguarding children across services: messages from research*, Department for Education, 2011; [www.gov.uk/government/publications/safeguarding-children-across-services-messages-from-research](http://www.gov.uk/government/publications/safeguarding-children-across-services-messages-from-research).

<sup>12</sup> C Davies and H Ward, *Safeguarding children across services: messages from research*, Department for Education, 2011; [www.gov.uk/government/publications/safeguarding-children-across-services-messages-from-research](http://www.gov.uk/government/publications/safeguarding-children-across-services-messages-from-research).

<sup>13</sup> C Davies and H Ward, *Safeguarding children across services: messages from research*, Department for Education, 2011; [www.gov.uk/government/publications/safeguarding-children-across-services-messages-from-research](http://www.gov.uk/government/publications/safeguarding-children-across-services-messages-from-research).

children is rising.<sup>14</sup> The Ofsted thematic inspection *Protecting disabled children* identified delays in disabled children who were suffering neglect receiving appropriate services.<sup>15</sup> The thematic inspection on joint working between children's services, adult mental health services and drug and alcohol services highlighted the lack of signposting to early help by adult services and particular delays in considering the impact of parental mental ill health on children.<sup>16</sup>

9. Neglect is a serious factor in the majority of serious case reviews (60%), and for children of all ages not just younger children.<sup>17</sup> Domestic abuse, mental ill health and/or substance misuse were common in households where children were neglected. Ofsted summaries of findings from serious case reviews highlight issues regarding inconsistency in the application of thresholds for neglect; poor professional understanding of neglect; difficulties in engaging with hostile or avoiding families; and professionals failing to provide sufficient challenge to parents in cases of neglect.<sup>18</sup>
10. Department for Education statistics show that neglect was the most common reason attributed to children becoming the subject of a child protection plan, accounting for 41% of cases (year to March 2013).<sup>19</sup> A major prevalence study of child abuse and neglect, published by the NSPCC in 2011 found neglect to be the most prevalent type of maltreatment in the family for all age groups.<sup>20</sup>
11. The picture then is one of continuing high levels of neglect with consistent findings from inspections and research highlighting the importance of early recognition; robust management oversight and supervision; specialist training; acknowledgement of the complexity of this work; and effective and timely professional responses to meet the needs of the child for both help and protection.

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<sup>14</sup> *The state of child neglect in the UK*, Action for Children and University of Stirling, 2013; [www.actionforchildren.org.uk/media/5120220/2013\\_neglect\\_fullreport](http://www.actionforchildren.org.uk/media/5120220/2013_neglect_fullreport).

<sup>15</sup> *Protecting disabled children* (120122), Ofsted, 2012; [www.ofsted.gov.uk/resources/120122](http://www.ofsted.gov.uk/resources/120122).

<sup>16</sup> *What about the children?* (130066), Ofsted, 2013; [www.ofsted.gov.uk/resources/130066](http://www.ofsted.gov.uk/resources/130066).

<sup>17</sup> M Brandon, P Sidebotham, S Bailey, P Belderson, C Hawley, C Ellis and M Megson, *New learning from serious case reviews: a two year report for 2009–2011*; Department for Education, 2012; [www.gov.uk/government/publications/new-learning-from-serious-case-reviews-a-2-year-report-for-2009-to-2011](http://www.gov.uk/government/publications/new-learning-from-serious-case-reviews-a-2-year-report-for-2009-to-2011)

<sup>18</sup> *Learning lessons from serious case reviews, 2009–2010* (100087), Ofsted, 2010; [www.ofsted.gov.uk/resources/learning-lessons-serious-case-reviews-2009-2010](http://www.ofsted.gov.uk/resources/learning-lessons-serious-case-reviews-2009-2010).

<sup>19</sup> *Characteristics of children in need in England: year ending March 2012*, Department for Education, 2012; [www.gov.uk/government/publications/characteristics-of-children-in-need-in-england-year-ending-march-2012](http://www.gov.uk/government/publications/characteristics-of-children-in-need-in-england-year-ending-march-2012)

<sup>20</sup> *Child abuse and neglect in the UK today*, NSPCC, 2011; [www.nspcc.org.uk/Inform/research/findings/child\\_abuse\\_neglect\\_research\\_wda84173.htm](http://www.nspcc.org.uk/Inform/research/findings/child_abuse_neglect_research_wda84173.htm).

## Methodology

12. This report summarises the findings of a thematic inspection by Ofsted exploring the response of professionals when they identify neglect, with a particular focus on children under 10 years of age.<sup>21</sup> Inspectors visited 11 local authority areas and examined a total of 124 cases. Fifty-five cases were examined in depth while the remainder were sampled. The areas visited varied in size and included counties and metropolitan areas with a mixture of rural and urban features.
13. In each area, inspectors met with professionals who had made referrals to children's social care and who had concerns about neglect. In addition, further samples of referrals were examined in each authority alongside a team manager. Inspectors also examined case records of longer-term work with practitioners and/or managers from children's services and then held discussions with the multi-agency group that was working with the family. Inspectors examined different stages of work from referrals, assessments and long-term work with children subject to child in need (CIN) and child protection (CP) plans. Cases where children had become looked after were also sampled and reviewed.
14. Inspectors met a legal adviser in each authority and a total of 20 parents. In addition, inspectors met with members of the Local Safeguarding Children Board (LSCB), and a group of social workers in each authority.
15. The key areas that the thematic inspection aimed to address were:
  - the timeliness and quality of referrals to children's social care and the effectiveness of responses to referrals
  - the quality of assessment and planning in cases of neglect and the degree to which these focus on the needs of the child
  - the range of interventions available to support children and their families and whether these are making a difference to children's lives
  - when children are subject to child in need and child protection plans and are not making progress, whether there is sufficient challenge to parents and among professionals to ensure that cases are escalated to the right level so that children are protected
  - in cases of neglect, whether the right action is taken at the right time to meet the child's needs and to protect them

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<sup>21</sup> In order for it to be possible to compare and contrast cases, and consider interventions and professionals involved across local authorities, only those cases where children were 10 years and younger were considered for the purpose of this thematic inspection. It is recognised however that neglect can affect all age groups and is of particular concern for adolescents.

- whether social workers are aware of research findings in relation to neglect and what specific impact this has on cases examined
  - the impact of training on practice with neglected children
  - how LSCBs evaluate the effectiveness of multi-agency work with neglect and whether they ensure that professionals have the training and support they need to do this work.
16. A small minority of cases were identified in this thematic inspection where there was evidence of considerable drift and delay in responding to the needs of children, although recent remedial action had been taken to ensure that they were protected. These cases were brought to the attention of the directors of children's services and in two instances inspectors recommended that management reviews should be conducted to ensure that lessons could be learnt.
17. Good practice examples from a range of authorities are highlighted in this report. These examples illustrate effective practice in a particular aspect of work, although this is not intended to suggest that practice in the local authority was exemplary in every respect.
18. This report is a collation of themes identified from across the 11 local authorities visited for the purpose of this survey, but not all findings in this report were evident in each local authority visit.
19. Where case studies are given, contextual details such as the child's age and/or gender may have been changed in order to maintain confidentiality.

## **Referring concerns about neglect to children's social care**

20. In total, 27 referrers were interviewed from a wide range of professions including the police; health visitors; housing professionals; teachers and learning mentors; a paediatrician; Accident and Emergency staff; a GP; a family support worker; children's centre workers; adult mental health staff; and social workers from Cafcass. A further 42 referrals concerning neglect were selected at random from a list of referrals received by children's social care over the last six months. These were examined by inspectors alongside a team manager.
21. The referrals reflected a range of concerns in relation to the home environment and children's presentation, concerns about children's behaviour, their health and development, and concerns about poor school attendance. In addition there were a high number of concerns about the emotional impact of neglectful parenting on children, including concerns about parental drug and alcohol misuse, domestic violence, parental mental ill-health and parents with learning disabilities.

22. In most cases the quality of referral information was sufficiently detailed for children’s social care to make a decision about the appropriate next steps, but in a few it was unclear and limited.
23. In some local authorities, targeted work had been undertaken with professionals to help them to write clear and coherent referrals for neglect, ensuring that the language used was specific and based on evidence. This was in recognition of the number of referrals received that were insufficiently clear as to the precise nature and extent of the neglect.

### **South Gloucestershire – Practitioner Tool Kit**

The Child Neglect Tool Kit for Practitioners is for practitioners whose work brings them into contact with children and their parents/ carers. The aim of the guidance is to establish a common understanding and threshold for intervention in cases where the neglect of children is a concern. The tool kit was developed following a serious case review in the authority that highlighted the lack of awareness within universal services about the indicators of neglect.

The tool kit includes definitions and possible causes of neglect, a framework for identification of neglect, and guidance on decision-making and thresholds, including guidance as to what to include in a referral to children’s social care. The guide supports practitioners to formulate their thinking about neglect and promotes a shared responsibility among professionals for identifying and responding to neglect. Its aim is to enable professionals to be clear as to whether to initiate a common assessment or refer to children’s social care. The tool kit has recently been piloted by a range of universal services and the feedback has been very positive.

24. Inspectors found evidence of early help through common and shared assessment in a third of the referrals reviewed. In most of these cases the intervention was appropriate and there had been timely escalation to children’s social care when plans were not working. In over half of the remaining cases there was sufficient evidence that a multi-agency early help plan should have been considered at an earlier stage. In one case, for example, a six-year-old child was referred by his school to children’s social care. He had been arriving at school very early having had no breakfast and having not washed or brushed his teeth. The child was coming to school in inappropriate clothing, with no coat in cold weather and was occasionally wetting. The child was brought to school by an older sibling and the mother had not engaged well with the school. The school had not considered initiating an early help assessment when they first became concerned, some months earlier.
25. Had a more proactive approach been applied in these cases identified by inspectors, and had concerns about neglect been recognised and assessed at an earlier stage, this could have resulted in a much earlier response. This could

have included, where necessary, escalation by means of a referral to children's social care which should have prevented further exposure to neglect.

26. The majority of the 27 referrers were satisfied with the response they received from children's social care. Of the five who were not, only one followed this up by querying the decision-making process. The theme of professionals failing to challenge other professional decision-making becomes apparent at later stages of the child's journey, and is a recurrent and concerning theme in a small number of cases.
27. There were many good examples of timely referrals resulting in an appropriate response from children's social care and good multi-agency working to assess the level of risk at the point of referral. For example:

A referral was made by a children's centre to children's social care concerning a three-year-old child who had four older brothers and sisters at school. During a home visit, the children's centre worker found conditions to be unkempt, dirty and unsafe for children. The parents did not appear to understand the concerns of the worker.

The worker collated information from the school about all the children and spoke to the health visitor. The children's centre rang children's social care for advice. It was agreed that a formal referral would be made but that a plan of action be put in place so that immediate funding was made available for clean bedding for the children and cleaning equipment. The children's centre staff worked with the family who were given one week to clean the house and to ensure the home was suitable and safe for the children.

There were worries about the parents' understanding of concerns and their ability to maintain the changes and an assessment was begun to further identify the risks to the children. The school and the health visitor were closely involved in the assessment. The prompt response from children's social care resulted in an immediate improvement in home conditions and the beginning of a more detailed assessment of the underlying causes of neglect.

28. In some cases seen by inspectors however, it was clear that the response from children's social care should have been more robust. For example, the rationale for not undertaking initial assessments was unclear, or had failed to consider all the presenting information. In some cases the possible options following a referral, such as the need for an early help assessment had not been considered.
29. A sizeable minority of cases involved past, and/ or current missed opportunities to intervene, to assess and to support children. Examples included children's social care services not gathering all the required information to inform

decision-making, and consequently missing the chance to undertake the appropriate assessments at the right time.

30. In some of these cases, referrals went back many years. For some it was clear that episodic and short-term intervention had temporarily reduced the impact of neglect, but that this was not followed by a sufficiently long period of support and the parent was unable to sustain the improvement. In other cases there was no evidence that intervention had led to improvements, nevertheless the cases were closed and repeated referrals were made in relation to the same issues.
31. Referrals were not always sufficiently well reviewed in the light of previous history. Incidents, rather than the child's ongoing experiences, were assessed and chronologies were either not used or were not robust enough to evidence the level of neglect and the impact of support. Only a small minority of referrers mentioned that the family history had an impact on their decision to refer.
32. This small cohort of cases demonstrates repeated patterns of missed opportunities to intervene at an earlier stage to address issues of neglect. Interventions stopped and started within a relatively short period of time, with evidence that children continued to experience neglect over a number of years. The cases showed that neglect is cyclical for some children and that many referrers often only have a partial understanding of the child's life and background.

The police made a referral to children's social care in early 2013 following a drugs raid on a house. They had found no drugs but were concerned about the house being dirty. The mother was pregnant. The family had been previously known to children's social care as one of the children had been subject to a child protection plan for 16 months for physical and emotional abuse. There had been a previous referral in the summer of 2012 when the school raised concerns that the mother was not taking the child for his medical appointments, and school attendance was poor.

Children's social care conducted an initial assessment. There was found to be a history of domestic violence in the family and the father admitted to using cannabis. The family was offered some family support and the case was closed. In respect of the most recent referral, the case was passed to the early intervention team to undertake an early help assessment. They visited the family but the parents would not accept any help.

The case exemplifies the poor use of case history, failure to consider the significance of new risks for a child previously the subject of a child protection plan, and the absence of decisive and authoritative action to protect the children from further harm.



## Assessment in cases of neglect

33. Some social workers reported that the use of standardised approaches (such as the Graded Care Profile) and comprehensive frameworks supported them to assess risk in neglect cases and to monitor change over time.<sup>22</sup> They reported that these methodologies enabled them to apply structure and systematic analysis to very complex situations and to identify key areas of risk. Having a clear focus on different aspects of neglect enabled social workers to effectively analyse the cumulative impact, which in turn informed better planning of intervention to support and protect the child. Not all authorities had adopted theoretical models and frameworks for assessment. Those that had were more likely to achieve consistency in standards of practice especially if social workers and managers were trained in using the model and managers were effective in quality assuring the standard of work.

### Signs of Safety – Northumberland

In 2010, Northumberland LSCB adopted the principles and practice of the Signs of Safety approach.<sup>23</sup> This encourages a shared multi-agency approach to child protection and enables the experiences and views of children to be heard and considered. The model was systematically implemented and embedded in all core processes during 2011 and 2012. Supervision models were developed for use with individuals or groups within children's social care and the safeguarding health teams.

Detailed policy documents and practice guidance were agreed and the necessary assessment and recording tools were integrated within the electronic social care record. An extensive multi-agency training programme for staff at all levels was launched with team managers, chairs of child protection conferences and specialist health and police staff receiving additional training. Signs of safety are integrated into induction for new staff.

Critically, implementation has focused on strengthening the quality of engagement with and understanding of children's experiences of abuse and/or neglect and its impact on them. Staff use a range of approaches including 'my safety house' and the 'three houses' with children to assess current risks to them and plan for their future safety.

<sup>22</sup> The Graded Care Profile was developed as a practical tool to give an objective measure of the care of children across all areas of need by Drs Polnay and Srivastava. The profile gives an indication of care on a graded scale;

[www.nspcc.org.uk/inform/resourcesforprofessionals/neglect/graded\\_care\\_profile](http://www.nspcc.org.uk/inform/resourcesforprofessionals/neglect/graded_care_profile).

<sup>23</sup> A sign of safety is a strengths-based and safety organised assessment and planning framework for child protection practice and was originally developed in Western Australia by Turnell and Edwards.

[www.signsofsafety.net](http://www.signsofsafety.net)

Early evaluation is positive and there is evidence that risk in cases of neglect is being more clearly identified and recorded. 'Signs of safety' is centred around engaging with the family in order to assess risk and to make better interventions based on an informed understanding of the likelihood of change.

34. The quality of assessments across authorities in this thematic inspection was too variable. Nearly half of the assessments did not take sufficient account of the family history. Even in those cases where the family history was recorded, this was not always analysed in terms of the patterns of previous episodes of abuse and neglect. The implications for the child of the parent's own childhood experiences and the impact on their current parenting were not always considered.
35. In a small number of cases, assessments made effective use of chronologies. However they were not routinely completed in all cases and most tended to focus on key events in the life of the family rather than a cumulative record of ongoing neglect and its impact on the child.
36. The importance of gathering evidence of the impact of neglect from an early stage was particularly important in those cases that progressed to care proceedings. One legal advisor reported that chronologies are sometimes only put together at the point that the decision is made to initiate proceedings. This is clearly far too late in the process.
37. Some assessments were comprehensive and child focused, with clear descriptions and analysis of the daily effects of living with neglect. Where this was seen, the descriptions of children's experiences were stark and powerful, for example:

'J' is a primary school-age boy and a carer for his mother who has used alcohol for many years. He is constantly anxious about his mother's well-being and attempts to control her drinking, while also caring for his younger sister. The child describes how he and his sister go to the pub with their mother most nights and the child says he does this to monitor his mother's drinking. The child tells his mother when to stop drinking and if she does not listen the child asks the barman to stop serving his mother. The child speaks of being at the pub 'very late, being really tired and hungry, wanting to go home to bed and mother refusing'. The assessment describes frequent occasions when there was a lack of food in the house and no bedding on the children's beds. The younger child is described as very emotionally distressed and has been seen by an educational psychologist who diagnosed her as 'hyper alert' and in need of one to one support in school at all times, to enable her to access education. The child speaks a great deal about death and dying, being burnt in her house and not living until the next day.

38. Other assessments conveyed the impact on children of poor school attendance, of living in homes where there is nowhere to play or to complete homework, having little food available and often no suitable bedding or sleeping arrangements. The impact of neglect in terms of education, health, social and emotional development, combined with the gross physical conditions that some children live with was clearly conveyed and considered in half of the assessments seen. The assessments that were most effective, however, considered not only the child's perspective and experiences, but also analysed the long-term prognosis for change and the potential long-term impact on children living with neglect.
39. However, very few assessments addressed all of these factors. Those assessments that were written for the purpose of the care proceedings were more likely to address these issues. The challenge for local authorities is to ensure that a high standard for chronologies, assessment addressing the cumulative impact and likelihood of change, and case summaries is achieved in all cases.
40. Some assessments focused almost exclusively on the parents' issues rather than on analysis of the impact of adult behaviours on children. This raises the question whether the complexity of some of the adult lives becomes the focus of the work as the parents' needs are so great, and professionals lose their focus. In some cases children became lost in the assessment in the same way in which they are lost within their own families. In such cases, management oversight was not effective, allowing the needs of the adults to dominate plans and decisions about next steps.
41. Some assessments were characterised by insufficient consideration of the parent-child relationship, with no consideration of attachment behaviour and a lack of attention to the child's emotional and physical development. There were a very small number of examples where it was evident from assessments that professionals had a limited understanding of children's presenting behaviour within the context of neglect. For example, children were described as having 'problematic behaviour' that needed to be 'managed' rather than their behaviour being understood as a manifestation of their emotional distress.
42. A lack of representation of the child's views, wishes and feelings was also evident in some cases and in families with large sibling groups; the individual needs of children and the impact of neglect on each child were not always identified and explored.
43. Training and support to enable social workers to understand and assess the complex range of children's emotional and behavioural difficulties and to convey the child's experience of neglect in assessment reports requires further development. Social workers need to have the skill and knowledge base to understand the range of behaviours that children experiencing neglect may present, including those children who present as resilient. Knowledge of

attachment behaviours and child development is fundamental and must underpin assessments of neglect.

44. The failure of assessments to effectively identify and analyse the level of risk and the impact of neglect on children has a serious and detrimental effect on the short- and long-term planning for some children. Poor assessments can and do result in children being left at risk of harm or being further harmed. Planning and interventions can only be effective if they are based on sound assessment. It is essential that the standards of good practice identified in some areas of this survey are replicated across the social care system. Organisations must take responsibility for ensuring that staff have the skills, time and the right balance of support and critical challenge to comprehensively assess risk in cases of neglect.

## Interventions

45. There was evidence of some very good support for children on 'child in need' and child protection plans which were meeting the short-term needs of the family. However, there was very little evidence of longer-term support being provided. A wide range of agencies were involved in supporting children and their families and in some cases the manner in which agencies worked together to meet the different needs of family members was impressive and resulted in good progress. For example:

A nurture group for parents based in the school was enabling a mother to build a better relationship with her children and to understand and respond more appropriately to their needs. To help build her self-esteem, the child attends the children's group which runs alongside the parents group. The family support team work with the mother on the importance of boundaries, routine, and the emotional impact of her parenting style. They also undertake one to one work with the three children to help them express their wishes and feelings. 'Homestart' provides practical and emotional support to the parents. The children's centre offers targeted support to the mother with her new baby through helping her understand the importance of play and communication. The mother also attends the Women's Aid Freedom Programme.

Positive progress was being made in the family. The mother has left her abusive relationship. The children all attend school regularly, are well clothed and are developing friendships with other children. The mother ensured that all children attended health appointments. The parenting had improved, with routines in place for the children and a more positive style of parenting.

46. Some interventions were designed to provide intensive support for families or to focus on specific issues such as substance misuse and domestic violence. Support to families worked well when it was targeted at identified needs; supported families with practical help; addressed the specific difficulties of

parents; the parent–child relationship; and provided direct work and support for children. Parents reported that what helped most was professionals finding time to talk and listen to their views. They appreciated workers who did not make them feel judged and who ‘got to know them’ and ‘understood the family’.

47. Services designed to support neglected children had been developed in a small number of authorities. The NSPCC and Action for Children were working in a small number of the authorities visited. NSPCC is piloting and evaluating a number of services across the UK to help tackle child neglect, including a range of parenting programmes and the graded care profile. Action for Children provides specialist early help for neglected children. Shortfalls in services were evident in some local authorities; professionals reported that cuts to local authority spending had impacted on a range of services, including a reduction in some of the services provided by children’s centres and in some areas a significant reduction in domestic abuse services.
48. Very few therapeutic services were available for children who had experienced long-term neglect. This is a particular concern given the high number of cases seen where children were exhibiting a range of very challenging behaviours and high levels of anxiety, including some very young children who were showing early signs of mental health difficulties. In many of the cases, parents required ongoing support to maintain improvements and prevent reoccurrence, but this was rarely available. The lack of ongoing support for some families was partly due to insufficient funding, but also there was evidence of over-optimism as to the ability of parents to sustain changes they had made to improve their parenting.
49. Effective multi-agency working was critical to the success of interventions. In a number of cases however, the absence of joint working between adult and children’s services impeded the progress of some plans and the ability of professionals to make informed and timely decisions.

In one case where the child was the subject of a child protection plan the multi-agency core group was providing a range of support to the family, with limited evidence of improvement in the home conditions and parenting of the children. Both parents had a history of drug misuse and were expected to attend the adult drug service. However, this agency did not attend core groups or case conferences despite numerous invitations and did not provide written reports. The agency did not respond to requests for information as to whether parents were attending for appointments and the outcome of drug testing. This had a serious impact on the ability of the group to assess parental engagement with the plan as they did not know whether parents were truthful about attending appointments or about the results of drug testing.

50. The challenges of effective joint working with adult services were raised repeatedly across most local authorities. This included social workers reporting

that they had difficulty in accessing appropriate assessments of adults with mental health difficulties to inform assessments of parenting. Schools were seen to play a key role and provided a wide range of support to children. The role of learning mentors in providing one to one support to children in schools was of particular value to neglected children. Many services in schools had a positive impact on children and for some the support they received enabled them to make positive progress. However, for other children the positive progress made at school was not always reflected in the home environment.

51. Although a number of cases demonstrated the effectiveness of multi-agency work, it is of concern that in a small minority of cases, schools did not have a full picture of the child's life at home and were not always well-informed as to the involvement of other agencies. While many examples of effective multi-agency working resulted in positive progress for children, there remain many areas for improvement. Shortfalls in services were evident; such as therapeutic support for children who are neglected. Joint working between adult and children's services remains an issue of concern as Ofsted highlighted in another recent thematic inspection.<sup>24</sup>

## Monitoring and reviewing the progress of cases

### Child in need and child protection plans

52. The quality of child in need and child protection plans was found to be highly variable. Where plans were of better quality, they were regularly updated, comprehensively addressed all issues identified through assessment, explicitly identified how neglect would be addressed, focused on both parents' and children's needs and contained clear and specific actions together with realistic timescales. Additionally, they clearly identified the different forms of neglect and risks for children. The change that was needed was clearly set out with well-targeted action, and the consequences of no change were made explicit within the plan.
53. Many plans however, were not specific about the changes that were required, how progress would be identified, and the timescales within which changes needed to occur. Parents receiving copies of these plans would be unclear what was expected of them and how quickly changes needed to be achieved. Few plans made reference to action that would be taken if risk remained or intensified. This was concerning given the nature and seriousness of the neglect. While child protection plans were more likely to make reference to further action, this was often insufficiently clear and expressed as 'take legal advice' and 'legal action'. One third of parents interviewed said they did not know what would happen if the plan was not successful.

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<sup>24</sup> *What about the children?* (130066), Ofsted, 2013; [www.ofsted.gov.uk/resources/130066](http://www.ofsted.gov.uk/resources/130066).

54. The poor quality of plans and the absence of specificity and consequence is not acceptable professional practice. All children should benefit from comprehensive written plans that detail key areas of risk, how these will be addressed and the specific action that will be taken (and by when) if the changes do not happen. This raises further questions concerning the effectiveness of quality assurance processes by managers in ensuring that plans are fit for purpose, and the degree of support and challenge that front-line staff receive in developing and revising plans. The need to drive improvement in the quality of child in need and child protection planning is a key finding in this thematic inspection.

## Measuring change

55. The challenge of monitoring and assessing change is recognised as a complex task in cases of neglect. In the cases seen by inspectors, although there was regular monitoring and review, this was sometimes compromised by the quality of the plans and the absence in many of clarity about changes and the consequences of no or limited change. Some local authorities have introduced specific material to support practitioners in assessing the degree of risk to a child, and then monitoring change over time.

### **The Change Tracker– South Gloucestershire**

The Change Tracker has been developed to improve the quality of planning and support offered at an early stage when concerns about a child are identified. It is used for children and families where there has been a common assessment and early help is available. The aim is to involve children, young people and their families in using the change tracker as a means of engaging them in the support and to help them in objectively defining their own needs and desired outcomes. The tracker identifies possible areas of concern with trigger points for referral to children’s social care. Scores are recorded on a tracker form so that concerns can be quantified before and after intervention. Schools are using the tracker to monitor children about whom they have concerns and report that it is particularly useful in cases where there are concerns about neglect.

### **Graded Care Profile – Wigan**

The use of the Graded Care Profile has been promoted in Wigan since 2009 as part of action to support evidence-based practice. It is strongly supported by the LSCB. Practice guidance has been developed alongside a programme of training for operational managers and front-line staff from social care, health organisations, the police and schools.

Multi-agency groups offering early help, support for children in need or overseeing child protection plans are expected to use the profile, in partnership with families. The purpose is to provide in-depth assessment of neglect and to monitor change over time.

Front-line social workers report that it is a highly valued resource. They described how its use helps them gain a better understanding of the ways in which parents perceive the level of care and supervision they provide. They also report that it enables differences in parental and professional perspectives to be explored and that the use of the tool over time enables change to be clearly mapped and understood.

Legal planning meetings ensure that the profile is used with all children for whom the threshold for care proceedings has been met. It is available as part of the evidence for applications to family proceedings courts. The use of the profile is monitored through routine and thematic case audits.

56. Not all authorities used specific methodologies to evaluate the extent of neglect and then to monitor change in families. Unless there are effective systems to establish baselines for the extent and nature of neglect, the development of effective plans to target intervention is very challenging. Local authorities need to ensure that social workers have systems and materials and the requisite skill to support them in monitoring and measuring the impact of neglect on children, and to help them establish whether change is resulting from their interventions.

### **Challenging lack of progress**

57. In over a third of the cases that were reviewed in depth for this thematic inspection, professionals should have challenged parents or other professionals because the plan was failing to achieve the necessary positive changes for children. In only some of these cases (eight) had professionals been able to make an effective challenge which had made a positive difference for the children involved. In four cases when professionals had escalated their concerns about the lack of progress to senior managers, they were informed that the parents needed to be given longer to work with the plan. In the remainder of the cases (seven) professionals did not offer challenge when they should have done to ensure that plans were progressing and meeting children's needs, including in some cases the need for protection.

For example – one child had been known to children's social care since moving to the area 18 months previously. He had been subject to a child in need and then a child protection plan. The child was only recently accommodated despite there having been evidence for many months that the child was subject to severe neglect and emotional abuse. Health professionals and the school stated that they thought the child should have been removed at an earlier stage but neither agency had escalated the case.



The chair of the child protection conference raised concerns with the senior manager but was told that the mother had not had enough time to work with the plan. Children's centre staff said that it was difficult to take action any earlier as the mother was acknowledging that things needed to change, and attended for sessions although there was little improvement in her parenting. The mother was described by agencies as 'deceptive' and she would not inform agencies when she had a new partner. Workers spoke of the mother knowing that she could lose her children but continuing to behave in the same way. All agencies had high levels of concern about the child who had made it clear to his family support worker that he did not want to live at home and was neglected.

No-one was clear about how to raise or escalate concerns about the safety of a child. Agencies collectively failed to act in accordance with their primary responsibility which is to protect the child and escalate concerns if they were not satisfied with the plan.

58. Child in need review meetings were mainly chaired by social workers and in some cases it was evident that this did not support effective challenge and monitoring of progress against plans. One multi-agency group reported that:
- 'The social worker chairs the child in need reviews and she struggles to send out minutes. The mum tends to take control of the meetings. It is difficult to challenge the parent and there can be too much discussion and not enough focus.'
59. A director of children's services commented that sometimes professionals see cases of neglect as 'unremarkable in the context of so many other cases'. They reported that social workers and schools in particular may become 'desensitised to neglect'.
60. In one authority, the use of independent conference chairs for child in need reviews showed an effective level of challenge. This service is, however, ending because of the pressure to reduce resources.
61. This absolute necessity for proactive and skilled management oversight in the complex area of neglect should not be understated. Professionals require visible and accessible managers so that they are supported to remain objective and to focus on the needs of the child. All staff working with families must be empowered to promote effective challenge in those cases where children's need for support and protection is not in place.

## Timely responses to neglect

62. Professionals did not consistently demonstrate a clear understanding of the short timescale in which changes to parental behaviour must be achieved if potential lifelong damage to children is to be avoided. Interventions in families

should ensure that, although neglect is appropriately assessed and parents are given support to make the necessary changes, the child's need for a safe and secure upbringing is not compromised by long periods of exposure to neglect.

## **The parent–professional relationship and strategies for engagement**

63. The challenge of working with neglect was apparent throughout the range of cases reviewed. The difficulties of alcohol dependency, mental ill-health and domestic violence were often compounded by other stress factors such as housing difficulties, financial pressures, social isolation, a lack of familial networks and in some cases, parental learning difficulties. Many of these parents are therefore highly vulnerable and unlikely to be motivated to engage with professionals. Despite these challenges, at the time of the thematic inspection in the majority of long-term cases examined proactive social work was resulting in progress for children. Of the 44 child in need and child protection cases reviewed, 27 were showing positive progress, four partial progress and 13 were not showing any progress. Of the 13 instances where progress was not being made, 11 of the children were subject to child protection plans.
64. There is a close relationship between improved outcomes and the effective engagement of parents. Where the most progress was made, agencies employed a range of approaches to work with parents which were consistent and clear, with frank and open discussions about the nature of their concerns and the changes that were expected.
65. Social workers used a number of techniques to support effective engagement, for example working alongside adult workers to use visual aids to communicate with parents with learning disabilities. The use of interpreters and written agreements helped to make clear what was expected of parents and the consequences if the required changes were not achieved. Agencies also developed a range of strategies to ease the path of engagement, such as support and transport to attend meetings, holding meetings at times and in venues that were convenient for the parents and visiting in the evening to ensure that both parents were seen. The combination of giving parents clear messages about the nature of concerns and expectations for change, together with practical support to enable families to engage, needs to be consistently applied in all cases of neglect.
66. In the cohort of cases where progress for children was not being achieved, a common feature was parental non-compliance or 'disguised compliance'. Professionals did not consistently demonstrate clear strategies to manage this behaviour. For example in a small number of cases, the Public Law Outline (PLO) was used to address non-compliance and while this was effective in the majority of cases, where parents breached PLO agreements subsequent action was not always taken. This apparent reluctance by professionals to act assertively and in line with written agreements meant that cases were not

escalated at the right time for children and there was a delay in action to protect them.

67. In some of the multi-agency meetings held during the thematic inspection professionals reflected on their practice and accepted, with hindsight, that they had been manipulated by parents. For example, in one case when a mother and father had a new baby, the child was made subject to a child protection plan because the parents both had a history of drug misuse and had had previous children removed due to neglect. When the mother tested positive for cocaine use and the father positive for heroin use, the case was escalated to PLO, but stepped down again very quickly when the parents appeared to cooperate with the plan. The child was removed from the parents some months later due to further evidence of parental drug misuse. The child protection chair told the inspector that they should have been more challenging of the lack of progress at a much earlier stage in the case, and described the parents as 'very plausible', 'always coming up with a reason for not completing tasks that were required of them'.
68. In other cases parents were given too many chances because professionals had not fully recognised or assessed the level of non-compliance and were carrying on regardless. Overall, the evidence in these longer-term cases is of a failure by professionals and their managers to be consistent in identifying non-compliance and disguised compliance, and in some cases failing to assertively challenge parents who were not engaging with plans.
69. Social workers have to engage and support parents with multiple difficulties, while focusing on the paramount concern of protecting the child. In order to achieve this balance they must be skilled and experienced, have effective support from experienced managers, supervision that is appropriately challenging and the full cooperation of all partner agencies.
70. The value of professionals having an opportunity to meet together and to reflect on practice became evident during the thematic inspection. Few opportunities for this exist within the 'child in need' and child protection planning processes. The benefits of such meetings would be that professionals could reflect on the challenges of working with neglect and identify patterns of parental behaviour that are impeding progress.
71. The significance of management oversight in ensuring that professionals are both supported and challenged in cases of neglect cannot be overstated. Managers and child protection chairs should be ensuring rigour in identifying and addressing parental non-compliance with plans. However this was not consistently evident in the cases reviewed.

## Further examples of drift and delay

72. In a third of the long-term cases examined there were examples of drift and delay and patterns of repeated stopping and starting of interventions with families. These were the cases of children in need, in need of protection and looked after children. The impact of this was a delay in taking the appropriate action at the right time to meet children's needs for support and protection. This includes 21% (11 cases) of the sample of long-term cases where there were missed opportunities for care proceedings to be initiated. This resulted in children left in situations of neglect for too long. In some cases this delay had a significant impact for the child, including a small number of cases where there was evidence of potential lifelong impact from living with long-term neglect.<sup>25</sup>
73. There was evidence in these cases of a repeated pattern of interventions which ended and then resumed, sometimes within a period of months. When services withdrew there was little formal monitoring to check that change had been sustained. Children moved between different levels of intervention, sometimes over a number of years. Each episode of neglect was seen in isolation so that the cumulative effect of neglect on the child was not appropriately assessed and understood. The pattern of stopping and starting interventions was particularly evident in those cases where parents misused drugs and alcohol and agencies were seen to respond to the changing patterns of parental engagement with services rather than the long-term impact of neglect on the child.

One mother had a long history of alcohol misuse which pre-dated the birth of her children. When she drinks heavily, the children move to live with different family members as she is no longer able to care for them. The mother engages with agencies when she is abstinent but disengages when she relapses. This had resulted in frequent stepping down and stepping up of the case. Professionals appear to respond to the mother's pattern of drinking rather than assessing the impact of her behaviour on the children in the long term. The impact on both children is evident, with one child in particular evidencing high levels of anxiety.

74. Further delays were apparent in some cases because of inconsistency in decisions about whether the threshold for proceedings had been met. A small minority of local authority legal advisers held the view that some courts were not giving enough consideration to the family history when making decisions as to whether the threshold for proceedings had been met. However, most legal advisers reported that the courts and Cafcass were well-informed about research findings and the significance of a history of parental neglect. In a further small minority of cases local authorities appeared too ready to accept

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<sup>25</sup> Many of these children were in fact in care at the time of the thematic inspection. However, when their cases were reviewed retrospectively inspectors identified missed opportunities for initiating care proceedings and removing children at an earlier point in time.

legal advice that the threshold for proceedings had not been met. This suggests there was some lack of clarity as to who holds responsibility for making decisions to initiate court proceedings to protect children from significant harm.

75. The general view of legal representatives was that the quality of written and verbal evidence provided by childcare professionals in legal proceedings was not consistently robust. This resulted in some cases failing to progress to proceedings or, when cases did reach the court arena, not achieving the required outcome. Evidence needed to be gathered more effectively, risks and protective factors expressed more clearly, and the impact or potential impact of neglect on children identified. Partner agencies needed to collate evidence of the impact of neglect, including the impact on children's behaviour and emotional development, from a very early stage. On the basis of this thematic inspection the lack of clarity around thresholds for legal proceedings is a significant concern, given that as a result of this some children remain in situations of neglect for too long.
76. In some cases it was found that placing children with extended family had caused delays in making permanent arrangements for children. Examples included two cases where the grandparents were colluding with the parents and allowing unauthorised access to the children. In addition, the grandparents were not open and honest about the extent of the parental drug use. In one case, a neighbouring authority had completed a positive assessment of a grandmother and the three children were placed with her subject to a special guardianship order. Despite mounting evidence that the grandmother was neglecting the children and failing to protect them from their father, who was a drug dealer and involved in violent gangs, the social worker appeared disempowered by the fact that a special guardianship order had been granted and in consequence failed to adequately challenge the care that the children were receiving.
77. These cases highlight the need for robust and realistic assessments of extended family members, with effective monitoring and support to sustain these placements. In addition, children's social care services need to ensure that appropriate legal safeguards are in place to provide long-term stability and security for the children.
78. Two further causes of delay were identified in a small number of cases. Practice in respect of families who frequently moved between authorities was sometimes insufficiently robust, and monitoring of repeated referrals which were indicative of ongoing neglect was not effective. Frequent changes of social worker also resulted in drift and delay which is of particular concern given the turnover of social work professionals nationally. Each new worker took time to engage with the family and to gather a full picture of the concerns. In some cases parents used the frequent changes of worker as a reason for their lack of engagement with child protection plans.

79. A wide range of factors can and do impact on whether neglected children receive a timely and effective response from professionals for support and protection. Parents may be reluctant to engage with professionals and in some cases professionals fail to challenge this, resulting in parents being given too many chances. Repeated patterns of interventions that stop and start were seen in some cases to result in episodes of neglect being seen in isolation, so that the cumulative impact of neglect on the child was not recognised. Delays in taking action to remove children resulted in some cases from a lack of clarity around thresholds for care proceedings. Legal advisers reported that in some instances the poor quality of written and verbal evidence presented to courts was resulting in delays. Placing children with extended families without robust and realistic assessment together with effective monitoring and support can cause further delay. Finally, frequent changes as families move between authorities, and changes in social workers can pose challenges to the effective monitoring of patterns of neglect over time.

## Supporting the workforce

### The challenges

80. Social workers described a range of challenges that they faced in working with neglect. The impact of making a positive difference was described by some as energising and motivating, 'Knowing you've done the right thing in the right timescale for the child.' There was a high level of congruence between what social workers said in group discussion and the challenges arising through the tracked cases. Achieving and sustaining successful engagement with parents is the greatest challenge, and more markedly so with child protection cases. Social workers highlighted the challenges of changing entrenched patterns of parental behaviour, giving all the children and young people in a family sufficient time and consideration and making sure fathers and male partners are involved in work. This area of work is both intellectually and emotionally challenging and some social workers had high caseloads, reporting that they had to manage their own challenges as well as managing the anxiety of other professionals.
81. Social workers overwhelmingly pointed to informal and formal support from colleagues and supervision from their line managers as most helpful in working with neglected children, enabling them to remain balanced and objective so that the needs of the child remain paramount. Few social workers, however, had access to multi-agency case consultation and supervision and no examples were seen of the use of external consultants to provide supervision and support.

### Training and research

82. In all of the local authorities visited as part of this review, LSCBs provided general child protection training that incorporated some level of focus on neglect.

83. The majority of LSCBs also provided specific neglect-related training that was sometimes linked to a specific initiative or priority relating to neglect. The extent to which this was mandatory varied. A few areas also held more informal learning events focused on aspects of neglect, such as learning lunches, workshops or one-day conferences. Most LSCBs were at an early stage in evaluating the impact of learning on subsequent practice with only a small number conducting follow-up surveys after the training to evaluate the impact on practice. The impact of training is not consistently evident in relation to actual practice.
84. Training is seen to have most impact when practitioners can make direct links between practice and training. Training that connects with professionals at an emotional level was seen to have particular impact on practice. In one authority a recent assessment training programme included a focus on the effects of neglect. Social workers spoke of the impact of seeing images of a brain scan of a three-year-old who had suffered neglect compared with a brain scan of a child who was developing normally. They spoke of how seeing this vivid image, which evidenced the graphic effect of neglect on the child's development, made them very aware of the short timeframe for professionals to intervene and to improve standards of parenting if they were to prevent the potential lifelong impact of neglect on the child.

#### **Northumberland Sand stories – keeping children in mind**

Following a local independent management review, the LSCB organised a programme of training to support staff to work more effectively with hostile and uncooperative parents in the context of neglect. Sand Stories was commissioned in July 2012 from an independent training provider. The key learning method is the visual enactment of a case study in which professionals across agencies are distracted by parents who focus on their own needs and the child's experience of neglect remains hidden. The learning is designed to engage participants cognitively and emotionally and to help them remain child-centred while recognising and tackling resistance from families. Research findings are woven into the programme. The training has a powerful impact and staff explained how this learning had changed their practice; for example, by enabling them to review children's needs and realise that current plans did not reflect the real depth of their needs.

A telephone survey completed one year later identified that the methodology had helped staff to retain the key learning messages through comments such as, 'I can still see the sand being sprinkled over the baby' and 'I always think "who is in the kitchen"'. Managers observed that 'it really made social workers recognise serious risks associated with neglect and the clear link between neglect and child death'. Front-line staff and managers also perceive that the more robust response to parental non-compliance which the training promoted is a key factor in explaining the

sharp increase in the number of child protection plans featuring neglect between June 2012 and June 2013.

85. All managers and social workers identified access to some research through a variety of means that included training; serious case review briefings; team meetings, including guest speakers; lunchtime seminars and away days. Most authorities gave staff access to external websites and one had access to an on-line journal.
86. Several groups of social workers identified challenges in actively using research. Finding time to access research was a challenge, one social worker commented: 'Research needs to be made accessible and meaningful. When we are busy we can't absorb it.' It was exceptional for front-line social workers to have access to specific rather than general research with a particular case. Professor Eileen Munro highlighted in her review of child protection' the need for social workers to make use of research to enable them to develop their practice.<sup>26</sup>

## Learning from serious case reviews

87. Where LSCBs had undertaken serious case reviews of cases of neglect, or other reviews, there was good evidence of learning and systematic action to improve practice: progress was seen, including:
- development of new policies for escalating concerns when children do not attend medical appointments
  - action to strengthen and clarify thresholds, such as strengthening health referral pathways
  - introducing new quality assurance processes, for example the introduction of case file audits in children's centres
  - equipping all practitioners to identify and respond to neglect by introducing a specific methodology to work with neglect
  - the development of 'concern cards' for housing workers so that if concerns are identified on a home visit these are recorded and tracked and referred to children's social care.
88. LSCBs have a duty to promote 'a culture of continuous learning and improvement across organisations that work together to safeguard and promote the welfare of children'.<sup>27</sup> It is imperative, therefore, that learning from case reviews, training and research is brought together in a way that is

<sup>26</sup> E Munro, Munro review of child protection: final report – a child centred system, Department for Education, 2011; [www.gov.uk/government/publications/munro-review-of-child-protection-final-report-a-child-centred-system](http://www.gov.uk/government/publications/munro-review-of-child-protection-final-report-a-child-centred-system).

<sup>27</sup> Working together to safeguard children, Department for Education, 2013; [www.education.gov.uk/aboutdfe/statutory/g00213160/working-together-to-safeguard-children](http://www.education.gov.uk/aboutdfe/statutory/g00213160/working-together-to-safeguard-children).



meaningful and accessible to front-line practitioners and their managers. LSCBs also have a duty to 'monitor and evaluate the effectiveness of training', but the findings from this survey suggest that evaluation of the impact of training on practice with neglect is not consistently evident. There needs to be a more consistent approach to the training of social workers with regard to neglect so that training both before and after qualification is mandatory. Local authorities need to share good practice so that the most effective aspects of training are promoted and accessible.

## **Strategic understanding of, and responses to, neglect**

89. Senior managers across all agencies understood the relationship between neglect, substance misuse, domestic violence and poverty. However, they did not have a clear picture or full understanding of how many children in their areas were vulnerable to, or suffered neglect, or whether local management and practice are reducing the incidence of neglect. This is of concern if the full picture of child abuse is not reflected in the local joint strategic needs assessments and the right breadth and range of services is not commissioned.
90. Only two LSCBs had undertaken work to clarify the numbers of children and young people affected by neglect across early help, child in need and child protection.
91. Most LSCBs did not receive or collect specific data about neglect except at the highest level, for example the percentage of child protection plans for neglect. This may underestimate the extent of neglect: for example, children may be subject to a plan for physical abuse but might also experience neglect. Only a very small number of LSCBs were able to present data in relation to the proportion of neglected children on child in need plans. Many LSCBs use a proxy measure, for example the incidence and reduction in repeat domestic violence incidents; but this does not enable local authorities to identify what proportion of children who benefited from a reduction in domestic violence are also better cared for and safe. Although many LSCBs scrutinised data relating to the quality of early help work taking place, only two had considered this in terms of the proportion of early help work that was related to neglect.
92. There are significant challenges for LSCBs in collecting the data and intelligence that would help them understand the full extent of neglect in their areas. The current DfE child in need data relies on categorisation at a high level of generality; for example referrals are classified as 'abuse and neglect'.<sup>28</sup> In addition, the updated version of the government's children's safeguarding performance information framework does not include Professor Eileen Munro's

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<sup>28</sup> Characteristics of children in need in England: year ending March 2012, Department for Education, 2012; [www.gov.uk/government/publications/characteristics-of-children-in-need-in-england-year-ending-march-2012](http://www.gov.uk/government/publications/characteristics-of-children-in-need-in-england-year-ending-march-2012).

recommendation that the reasons for referral should be included.<sup>29</sup> The pervasiveness of neglect as a feature of all other forms of abuse, and its relationship with deprivation, in itself presents a challenge to LSCBs. Some were working to overcome these challenges in order to understand more fully the needs of children and young people in their area.

93. The core objective for LSCBs is to coordinate what is done by each person or body represented on the Board, for the purposes of safeguarding and promoting the welfare of children in the area, and to ensure the effectiveness of what is done by each such person or body for those purposes.<sup>30</sup>
94. Given that most LSCBs do not fully understand the extent of neglect in their area, it is unsurprising therefore that most were not able to provide robust evidence of the effectiveness of multi-agency action to tackle neglect.

### **Lancashire: a whole-system approach to neglect**

In 2012, Lancashire County Council undertook a programme of research to gain an understanding of the extent of neglect in Lancashire. The key aim was to define the characteristics of neglect; to determine what good outcomes for neglected children are; and to understand the experiences of families; with the intention that findings would provide an evidence base for creating a Lancashire neglect strategy. The research included: a literature review; parent interviews; staff focus groups; a child focus group; case audits; child protection case studies; and a directorate-wide staff survey. The authority learnt that multi-agency services did not respond to neglect at an early enough stage to try to prevent the need for the involvement of children's social care.

As a result, a number of key principles were developed to underpin a neglect strategy, including:

- promoting of practice that focuses on parents taking responsibility and being empowered to make sustainable positive changes to their own and their children's lives
- improving the understanding of early signs of neglect, short-term and long-term neglect, to determine the most appropriate course of action
- developing the ability to measure and quantify outcomes for children and the impact of neglect on their development
- establishing clear and consistent thresholds for progression to care proceedings.

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<sup>29</sup> Children's safeguarding performance information framework, Department for Education, 2013; [www.education.gov.uk/childrenandyoungpeople/safeguardingchildren/protection/b00209694/perf-info](http://www.education.gov.uk/childrenandyoungpeople/safeguardingchildren/protection/b00209694/perf-info).

<sup>30</sup> Children Act 2004; [www.legislation.gov.uk/ukpga/2004/31/section/14](http://www.legislation.gov.uk/ukpga/2004/31/section/14).

Neglect was identified as a strategic priority by the LSCB for the financial year 2012/13. Through its quality assurance and business planning framework the Board reviewed its multi-agency performance and quality assurance information, its practitioner and manager training and agreed to participate in the national pilot of the Graded Care Profile neglect assessment tool (led by the NSPCC). The LSCB has recently produced supervision standards for all agencies and offers training and briefings to support this.

The strategy was formally launched in September 2013. This range of initiatives demonstrates good leadership, effective partnership working and a clear drive to improve the lives of children experiencing neglect. However the Board acknowledges that there is still much work to be done to ensure that this front-line work is consistently effective. .

95. All LSCBs had published a multi-agency threshold policy and guidance document. The extent to which these were specific and clear in relation to indicators of neglect varied considerably. Neglect-specific criteria were generally scattered throughout the documents on the grounds that neglect often underpins other forms of abuse.
96. Most documents did not distinguish between recently identified neglect and long-term patterns of neglect. A few authorities had developed supplementary neglect-specific criteria through their use of the Graded Care Profile.
97. Only two LSCBs had a neglect strategy and one had a draft strategy subject to consultation. In other areas, LSCBs took the view that neglect could be subsumed into other strategic plans, such as those addressing domestic abuse and 'Hidden Harm'. The risk to this approach is that neglect is insufficiently profiled as a key priority. It is also more likely as a result that LSCBs are compromised in their duty to monitor and evaluate the effectiveness of action to prevent and reduce the impact of neglect.
98. All LSCBs reported that neglect issues were a key component of their ongoing case audits of multi-agency child protection practice. Despite this, only three had undertaken neglect-related audits in the last three years. This adds to the challenges in obtaining a full picture of the effectiveness of work with neglect. Where specific audits were undertaken important findings emerged. One local authority had undertaken a multi-agency audit of 68 neglect cases and had established that there was serious inconsistency in the identification of neglected children whose families were accessing universal and preventative services. This led to commissioning of local research and the development of dedicated approaches to support the assessment of neglect.

## Conclusion

99. The quality of professional practice in cases of neglect is too variable, both between and within local authorities and by partner agencies. Some parents are given too many chances and some children are left in situations of neglect for far too long, with potentially very serious consequences. This is of serious concern. While examples of good practice were identified during the inspection and effective approaches to neglect were seen to make a positive difference for many children, this standard of practice was not consistent. Drift and delay featured in a third of all long-term cases and derived from inadequate assessments; poor planning; parents failing to engage; lack of professional challenge; and limited understanding by professionals of the cumulative impact of neglect on children's well-being and development.
100. There is an urgent need for improvement in the quality of practice across the system. The child's experiences, from the first intervention by professionals, must be clearly assessed, recorded and understood. The cumulative impact on children of both persistent and intermittent neglect must be a central concern when considering next best steps to protect them. Authoritative decisions made in good time will only be possible if there is effective oversight from managers through regular high-quality supervision. Assessments need to become an integral part of engaging directly with families to understand what life is like for the child or children living there.
101. Decisions about risk and associated plans need to be clear, regularly reviewed and where risk remains or intensifies, the consequences of, and timescales for, action should be agreed by all professionals and understood by children and their families. Professionals working in this field need to be highly skilled, trained and appropriately supported by managers to assert their professional authority to challenge each other, and parents and carers who are not engaging effectively, to improve outcomes for their children.
102. In addition, a strategic approach to neglect is required. One that ensures a sufficient understanding of the extent of neglect and that also serves to drive improvement in practice.
103. This thematic inspection has highlighted a real urgency for improvements to be made in driving up standards of professional practice and leadership in the field of neglect. The challenges of working with neglected children are clear, but proactive social work, including early recognition; comprehensive child-focused assessments; careful planning; regular review; and rigorous case management, was seen in some cases during this thematic inspection and was making a real difference to the lives of children. The use of evidence-based methodologies to address neglect was valued by professionals and was making a positive difference to managing the complexity of neglect in many cases.
104. The challenge is for local authorities and partner agencies to learn lessons from those cases where professional responses are timely and effective and ensure

that children are protected. Professionals need to share and promote good practice so that the child's experience is always at the centre of professional decisions, and to prevent their needs from becoming lost in the complexity of managing neglect.

## **Annex A: local authorities subject to this survey**

Haringey  
Lancashire  
Liverpool  
Manchester  
North East Lincolnshire  
Northumberland  
South Gloucestershire  
Surrey  
Tower Hamlets  
Wigan  
Wolverhampton