SURREY SAFEGUARDING CHILD PROTECTION PLAN UNDER THE CATEGORY OF NEGLECT 2016/17

Introduction:

Neglect is one of the four key priorities for Surrey Safeguarding Children Board (SSCB) in 2016/17. Child neglect is not easily identifiable, but it can lead to chronic maltreatment over many years. It can also have a considerable detrimental impact on physical, emotional and social health, with impact often persisting into adulthood. Some of the recent Serious Case Reviews highlighted the devastating consequences of delayed or appropriate actions for children in CP plan. There were five Serious Case Reviews conducted in Surrey in 2016. Out of those five, two were on a CP plan under the category of neglect. Therefore managing neglect with timely intervention and support are essential for children on a CP plan.

Methodology:

A children's multiagency case file audit of sixteen children from across Surrey on a CP plan under the category of neglect was carried out with partner agencies. The focus of the audit and the children's case file audit tool were developed in consultation with the SSCB Neglect subgroup and partner agencies. The tool was designed to gather qualitative information to explore whether:

- Children are appropriately involved
- Children are safeguarded and risk is managed by partners (risk identification, assessment and decision making)
- Good working with partner agencies
- Staff are supported
- Diversity
- Outcomes for children and families

Outcome:

A clear and SMART action plan was developed based on the recommendations below (what needs to happen next?). The action plan is monitored through the SSCB Neglect Sub-Group.

What's working well?	What are we worried about?
Children, young people and families were involved and views were collected and recorded in most of the children's case files we audited	The audit suggests that children tend to go through a cycle of improvement and deterioration. Some children came off the CP plan when their situation improved and then moved back to the plan when improvement was not sustained and/or new issues emerged.
Effective information sharing and coordination between agencies were evident and resulted in better outcomes for children	Delays in commissioning assessments in Public Law Outline (PLO)
All the families audited received relevant support from various agencies including Children Services, Schools and Health. Coordinated multiagency support also resulted in better outcomes in some children's cases	Professionals in schools who are working with children do not receive safeguarding supervision or additional support
Proper consideration was given to disability issues and appropriate supports were put in place according to the evidence received	The audit did not show the use of any specific tools to support practitioners' assessment and identification of neglect, although there is evidence of tools from the Safer Surrey approach being incorporated into some direct work
Timely identification of risk of Child Sexual Exploitation (CSE) and addressing the issues effectively	Audit suggests inconsistent multiagency attendance at case conferences. Also there are issues with regularity of Core Groups and safeguarding supervision
The transfer of CP plan from and to another area showed good example of effective transfer process	Transition between health services for children post 18 years is not robust. This is mainly due to the fact that many services do not exist for adults and as a result some if the supports stop when a child turns 18

Families were signposted consistently to relevant services where they can benefit from including outreach providers and counselling services	General delays in legal procedures such as Special Guardianship Order
Evidence suggests that relevant actions were taken for unborn children to ensure that the child is safe when born. Good examples of multiagency work and special considerations made to explore safer options to keep mother and child together	Families not understanding the benefit of the supports provided by mental health and domestic abuse services and therefore often reluctant to take up some of the valuable services

What needs to happen next?

- Parental mental health and learning difficulties came up as one of the most common contributory factors in the audit. Further work needs to be carried out to explore how to provide ongoing support to families with parental mental health and learning difficulties effectively as a CP plan may not be the most effective way to address families with complex mental health and learning difficulty issues
- Clear and consistent neglect risk assessment tool to be rolled out across the partner agencies
- The audit highlighted that there are significant delays in getting specialist assessments completed in PLO process. The audit suggests that this could have a negative impact on children's lives and could cause drift. Children's Services has also carried out reviews to explore this further and are taking relevant actions to address this. There needs to be clear procedure in place to ensure that multi-agency work continues as normal whilst a family is waiting for assessments so that families continue to receive support they need and to avoid drift
- Evidence suggests that families go through a cycle of improvement followed by deterioration. When improvement happens and a child is considered no longer at risk of significant harm, the child steps down to a Child in Need (CiN) plan. However, the audit of children with repeat CP plans suggests that improvement made whilst the child is on a CP plan is not always sustained after stepping down to a CiN plan. The CP step down process requires special consideration to ensure that sustained improvement can be achieved
- Lack of coordination between agencies in some cases resulted in a lack of escalation at an earlier stage and ultimately led to drift. All agencies need to support work in reducing drift and targeting support at an earlier stage
- The SSCB training team and partner agencies need to continue to emphasise the importance of the voice of child and continue to provide training on disguised compliance
- The audit also suggests that Core Groups and supervision are not taking place regularly for some children's cases. The SSCB will be reviewing the Core Group process in early 2017. A further audit on supervision may be necessary to explore this further
- More work needs to be carried out to explore how to engage families who are not able to see the benefits of some of the services, especially with parents who may have mental health issues or are suffering from domestic abuse.
- The SSCB Neglect subgroup has identified that it is necessary to report on some of the available data on neglect in order to understand the prevalence of neglect in Surrey as well as to measure the impact of some of the work being carried out. In future the SSCB report card will include a section on neglect

Further information and resources:

- SSCB Training Programme
- SSCB Policy and Procedures
- Child neglect: Be professionally curious! Practitioners' guidance notes
- SSCB Multi Agency Neglect Risk Assessment Tool
- SSCB Levels of Need Threshold Document
- SSCB Escalation Policy
- NSPCCs factsheets on neglect
- Ofsted's report In the child's time: professional responses to neglect

If you are concerned about the safety of a child, young person or an adult you can contact our Multi-Agency Safeguarding Hub (MASH). 9am to 5pm, Monday to Friday.

Phone: 0300 470 9100
Email: mash@surreycc.gov.uk

Out of hours phone: 01483 517898 to speak to the emergency duty team.