Neglect Audit

01 Background

A multi-agency audit of cases in Northumberland was undertaken to inform NSCB of the response by partner agencies to neglect in the county. Agencies participating included, health, education, early help, police, children's social care and housing. Eighteen cases were reviewed with sixty three audits returned for analysis.

Why it matters 02

Neglect is a recurring feature in serious case reviews nationally. Within Northumberland, neglect is identified as a significant feature in the majority of cases of children subject to child protection plans. NSCB wanted to understand whether there is a common understanding and shared response to neglect cases.

03 Information

Analysis of the audit information highlighted how the chosen tool was easier for some agencies to use than and less relevant to others. For future use, the tool has been adapted to make it more relevant to all agencies.

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Learning from the process identified some common areas for development, these include:

- Recognising the signs of neglect. Professionals did not often refer to the term 'neglect' in documentation. "Identify the key issues and name the difficulty as neglect"
- Use of chronologies. In only 37% of cases was a chronology recorded. Auditors identified a chronology would be useful in recognising the patterns of neglect.

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- Involvement of fathers. In 66% of cases, there was insufficient evidence to demonstrate enough information was gathered about the father as part of the assessment. "Professionals visiting have an understanding that Dad absents himself when they are visiting, which throws up concerns about his role in the family".
- Cases drifting. In 26% of cases there was evidence the case had drifted often demonstrated by lack of follow up and updating of information.
- Seeing children alone. Only half of the cases show children were seen and spoken to alone. However, there were also some examples of excellent direct work with children.

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- Identification of the toxic trio (a combination of domestic abuse, mental health and substance misuse issues). These issues were not always linked or identified as concerning and therefore not associated with neglect.

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There was also evidence of good practice including:

- Information sharing. In over 70% of cases this was seen to be positive and the collaborative approach informed the planning for the families. " communication between agencies to establish the picture for the family"
- Responsiveness to risk. In almost 70% of cases the risks were identified and responded to appropriately.
- Management oversight of cases. In 88% of cases it was demonstrated management oversight was appropriate and concerns escalated as needed.

What to do

What we can see is that agencies usually are communicating with each other and sharing information. When risk are identified, they're responded to and thresholds applied in most cases.

To improve practice, partner agencies need to identify the toxic trio and then relate this to neglect. This requires good professional supervision and awareness raising through this and training.

It is important to use a chronology as a working tool to recognise emerging themes and patterns and therefore prevent drift and delay in responding to neglect cases.
In order to have an in-depth, holistic assessment of the case, it is crucial relevant information is sought regarding all family members including fathers.

What next,

- NSCB representatives to share this briefing with all relevant staff.
- To be included in single and multi-agency training.
- NSCB to consider a schedule of future audits on an on-going basis.