


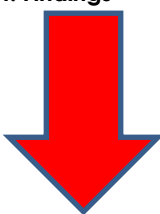




7 MINUTE BRIEFING – NEGLECT THEMED SCR

 1. Background	<p>In 2016 and 2017, two babies from different families came to the attention of West Lothian Child Protection Committee for experiencing significant harm in the first six months of their lives. One baby (Case 1) was accommodated, but later returned to her mother. The second baby (Case 2) died at six months. In both cases, there were issues of significant neglect.</p> <p>In 2018, West Lothian surveyed workers across social work, education, health and police about recognising and responding to neglect of the children and young people they work with. From a total of 563 responses it emerged that, while professionals generally recognised neglect in children and young people, many reported a lack of confidence and an uncertainty in how to respond.</p>
 2. SCR	<p>West Lothian Child Protection Committee (CPC) conducts Significant Case Reviews (SCRs) in line with National Guidance</p> <p>In Scotland, SCRs examine the circumstances and context of a child being harmed or killed, to evaluate the nature and quality of professional contact with the child, to identify any system failures which may impact on other children, and to learn from the incident lessons which will strengthen child protection systems, locally and nationally. SCRs should be seen in the context of a culture of continuous improvement and should focus on learning and reflection on day-to-day practices, and the systems within which those practices operate.</p>
 3. Learning Together	<p>Child neglect has been recognised in West Lothian as an issue that has emerged from Initial Case Reviews and multi-agency audit activity. Recognising and responding to neglect continues to be challenging for professionals across agencies. The decision was taken by West Lothian Chief Officers' Group to undertake a Learning Together themed review to support better identification of systemic barriers to (and enablers of) good practice in supporting and working with families and children experiencing neglect. A themed review applies the <i>Learning Together</i> methodology and blends scoping a wider number of cases where neglect features and a more in-depth review of two or more cases to incorporate the breadth and depth of learning.</p> <p>The Research questions for the review were:</p> <ol style="list-style-type: none"> How well do practitioners across agencies in West Lothian recognise and respond to the neglect of children under two years? What helps or hinders practice in responding to children? What helps or hinders agencies working together in recognising and responding to neglect?
 4. Findings	<p>Finding 1 (both cases) Without consistent use of assessment framework and tools, practitioners struggle to identify or respond to children who may be experiencing neglect leaving some inadvertently at risk of significant harm</p> <p>Finding 2 (case 2) The impact of parental mental ill-health on parenting capacity is not consistently recognised or understood across all child or adult focused services which can leave children living in situations which may put them at risk</p> <p>Finding 3 (both cases) Across agencies, the lack of chronologies of children and families affects practitioners' ability to identify patterns of concerns, the accumulation of neglect and to respond appropriately which means that children may be living in circumstances detrimental to their health, wellbeing and development.</p>
 5. Findings	<p>Finding 4 (both cases) There is no formal oversight or review of the outcomes of intervention provided via the Screening Groups meaning that the impact on some parents is likely to be less beneficial with children experiencing little change</p> <p>Finding 5 (both cases) Professionals in universal services are increasingly managing complex situations without adequate challenge, support or oversight of their practice or decision-making leading to some children being at risk of significant harm for longer periods than necessary</p> <p>Finding 6 (both cases) A lack of clarity about the role and expectations of the named person can lead to agencies working with a family in isolation and patterns of behaviour and accumulation of concerns going unnoticed</p> <p>Finding 7 (both cases) Verbal referrals to social work can result in miscommunication and misunderstanding resulting in different expectations about the purpose of the discussion leading to an inappropriate response for children who may be at risk of significant harm</p>
 6. Why does this matter?	<p>To experience neglect is one of the most profoundly damaging childhood experiences. There is now an overwhelming body of research that evidences just how harmful neglect can be to emotional, behavioural and cognitive development in the short and long term (Daniel, Taylor and Scott 2009). These affect life chances and contribute significantly to widening social, economic and health inequalities. Evidence suggests that one in ten children in the UK experience neglect and that it is the most prevalent form of child maltreatment (Radford et al. 2011). Assessing and reducing the effects of neglect in families is complex and challenging. Neglect is multi-faceted and often the greatest uncertainty is in deciding the seriousness of a situation and identifying ways in which to intervene in order to improve outcomes for children. Professionals in all agencies need to be mindful that their information is only one piece of the jigsaw and that others may have more information to help build a clearer picture; this is particularly true in cases where the evidence for neglect is not obvious and likely to fluctuate over time.</p>
7. Discussion for Team Meetings and Supervision	<ol style="list-style-type: none"> Do you recognise the findings? West Lothian decided that the Graded Care Profile is the assessment tool that should be used when neglect is suspected or confirmed but its use is not consistent –why is this? How could we improve consistent use? Do you feel confident about your knowledge of mental health issues and how these impact on parenting? Are you confident about which types of interventions work best with people with mental health problems? Who would you get information from? Are there any barriers to getting this information? If so, what would improve this? Do you use your single agency chronology as a tool to identify patterns, concerns? Is it discussed in supervision? The multi-agency chronology produced by core groups is meant to be used as a tool –do core groups use it in this way? If not, why not? What are the barriers to using chronologies effectively? What would improve this?

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	<ol style="list-style-type: none">6. If a family you are working with has had previous interventions is it clear what the objective of the intervention was and the outcomes of that intervention? Is it clear what is meant by engagement? What could improve this?7. If you are practitioner from a universal service you may find that in the named person of lead professional role you are managing complex situations –who do you get support/supervision from? Who has oversight of what you are doing? What kind of support/supervision would be useful for you?8. Named Person/Lead Professional -Are you clear about the child planning process in West Lothian? Are you clear about what is expecting of you as the named person or lead professional? Do you think of the family as a whole or focus on the child involved with your agency/service?9. Have you made a referral to SW that has been misunderstood or you felt was responded to with less urgency or seriousness than you would have expected?10. Do you know how to escalate the matter if you are unhappy with the response you get?11. What would ensure that concerns raised are understood better?12. Would a written follow up to a verbal referral make things easier?13. Is there a lack of trust between agencies?14. Is there a lack of respect for the professional opinions of those outside your own agency or profession? If so, how could this be improved?
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The Neglect themed SCR can be found here: [Executive Summary Neglect Themed SCR](#)

The CPC's Escalation Procedure can be found here: [Escalation-Dispute-Resolution-Procedure](#)