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# 1 Introduction

## 1.1 Statutory Guidance

The statutory guidance *Working Together to Safeguard Children* (2018) outlines the criteria that trigger the allegations management procedure. The procedure applies when there is an allegation that any person who works with children, in connection with their employment or voluntary activity, has:

- Behaved in a way that has harmed a child, or may have harmed a child;
- Possibly committed a criminal offence against or related to a child;
- Behaved towards a child or children in a way that indicates they pose a risk of harm to children.

The guidance sets out the importance that the co-ordination of any actions to address welfare concerns, in relation to the child or children involved, are taken without delay. It stipulates that local authorities should have a *designated officer* – aka Local Authority Designated Officer (LADO), or team of officers, to be involved in the management and oversight of allegations against people that work with children.

## 1.2 Managing Allegations Procedure

The detail of the procedure to manage allegations against people who work with children for schools is contained within the statutory guidance – ‘Keeping Children Safe in Education’ (2018), Part 4.

For all other organisations the procedure falls within the South West Child Protection Procedures:

[http://www.proceduresonline.com/swcpp/somerset/p\\_alleg\\_against\\_staff.html](http://www.proceduresonline.com/swcpp/somerset/p_alleg_against_staff.html)

Inappropriate behaviour by those who work with children should be considered within the context of physical, sexual, emotional abuse or neglect – failure in the duty of care to safeguard children.

This will include concerns about inappropriate relationships between staff / volunteers and children. For instance, where professional boundaries are not maintained and employees / volunteers breach policies e.g. a worker having contact online with a young person through social networking sites.

## **1.3 Role and Responsibilities**

### **1.3.1 Role of the LADO (Local Authority Designated Officer)**

The role of the LADO is to:

- Provide advice and guidance to employers and voluntary organisations
- Liaise with the police, children's social care and other relevant agencies;
- Monitor the progress of cases to ensure that they are dealt with as quickly as possible, consistent with a thorough and fair process.

### **1.3.2 Role of Employers**

The role of employers is to: -

- Appoint a designated senior manager to whom allegations or concerns should be reported;
- Appoint a deputy to whom reports should be made in the absence of the designated senior manager or where that person is the subject of the allegation or concern.

### **1.3.3 Role of Police**

Avon and Somerset Constabulary through the Lighthouse Safeguarding Unit – Southern (SCU), provides the following support:

- Availability for strategy discussions / meetings;
- Consulting with the LADO on notifications received to determine if there is a role for the Police;
- Reviewing progress of cases in which there is a police investigation;
- Sharing information on operational cases as appropriate including confirmation of the outcomes upon completion of investigations or related prosecutions.

## **1.4 System for Dealing with Notifications**

The system of recording and managing referrals, including LADO notifications, being processed through Somerset Direct ensures a first point of contact to determine whether the threshold for children social care involvement is met.

This process enables the managing allegations procedure to be compliant with DfE expectations in terms of there being a single point of contact for all notifications to ensure the safety of children is determined at the earliest stage.

Organisations are required to complete an **Allegations Reporting Form** (ARF) before advice, guidance and support is received from the LADO Service.

## 2. Data and Information on Notifications - 2018 / 2019

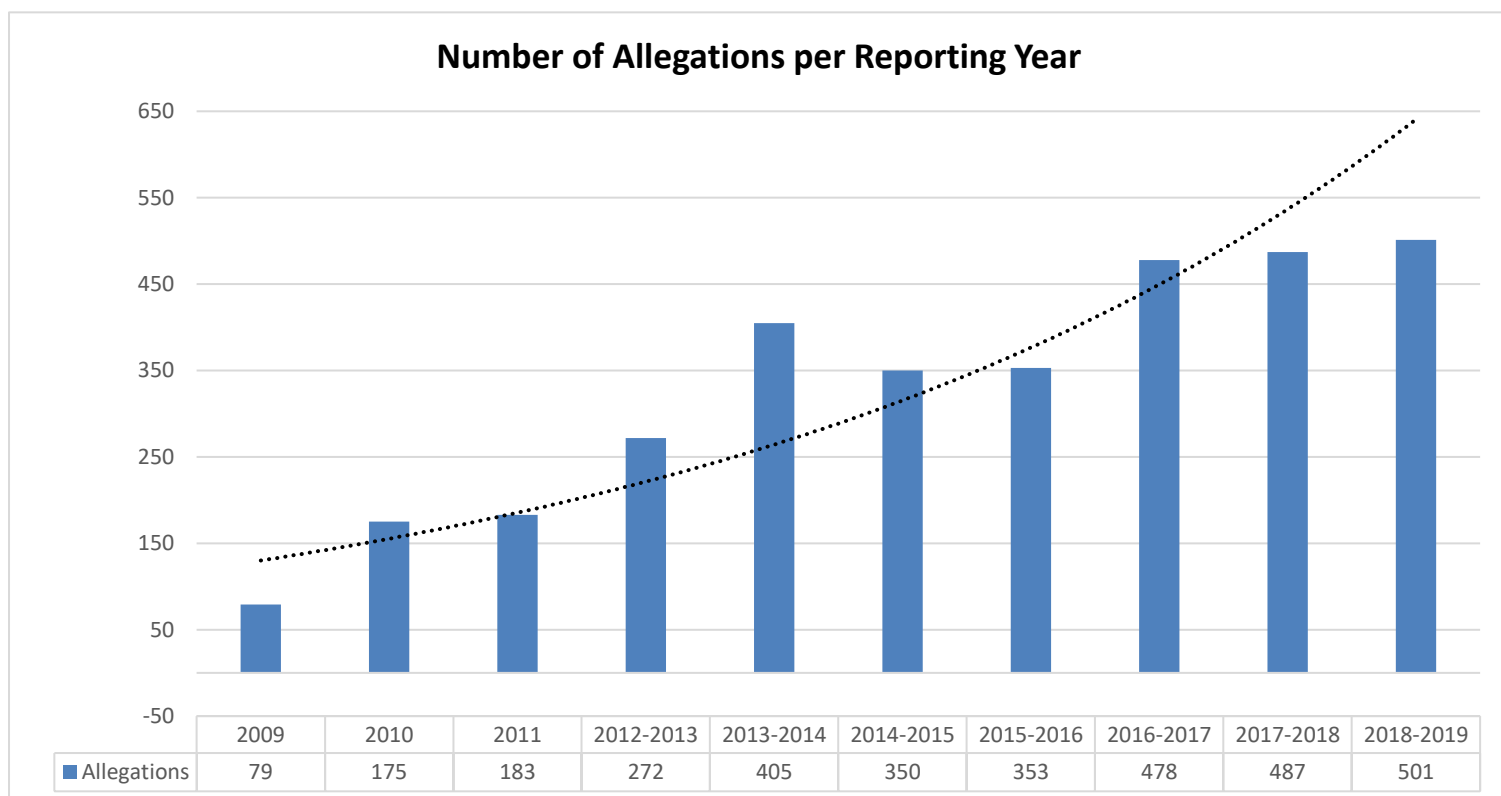
### 2.1 Contacts

During this reporting year a total of 548 'contacts' were made with the LADO Service. A 'contact' being defined as any information received that required an initial assessment and / or further research to determine if the issue falls under the managing allegations procedure.

Of these 548 contacts this breaks down as follows:

- ARFs received – **501**
- 'No ARFs' - **47** – consider of information that indicates an adult may pose a risk of harm to children

The ARFs received can be broken down further in terms of outcomes: -



The LADO was notified of 501 allegations during the year. This means that the LADO dealt with 14 more allegations than in the previous reporting year. This represents approximately a 3% increase in notifications from the previous year. This percentage increase is in line with previous years.

This has a cumulative effect on the capacity of the service and is identified as an on-going issue.

The high number of notifications is often due to organisations seeking clarity as to whether or not the alleged incident meets the criteria to trigger the managing allegations procedure. Anecdotally many of the contacts received can be attributed to the notifier lacking the confidence to determine if any of the criteria are met and / or wishing to have an audit trail of consultation with the LADO.

As a result of this a new version of the ARF has been issued. This enables professionals to seek advice and guidance without necessarily providing personal details of the adult or young person. This ensures compliance with data protection and human rights requirements given the incident may not meet the criteria to trigger the managing allegations procedure. If after initial assessment of an ARF seeking advice and guidance, the LADO determines the threshold is met, then personal details of both the adult and child will be sought.

The introduction of the option on the ARF to seek advice and guidance will aide children's residential homes who often make notifications having already determined that the incident does not meet any of the criteria. This is done in order to avoid undue criticism from Ofsted who expect all incidences to be notified to the LADO irrespective of whether the home can evidence that the incident does not meet any of the criteria.

Where names have been provided then such notifications can potentially be invaluable as it enables the cross referencing of names to the existing database. This gives the ability to detect any emerging patterns of concerning behaviour by a named adult at an early stage, or the involvement of a child in previous notifications.

Additionally, completion and return of an Allegations Reporting Form (ARF) serves as an official record of consultation between organisation and the LADO Service.

The importance of recording advice and guidance is highlighted in the serious case review report (East Sussex Safeguarding Children Board - Child G – A Serious Case Review) which states, the LADO is "*personally and professionally responsible for ensuring that consultations are conducted and recorded*"

*appropriately*' (Harrington, K, 2013, pp15-16). As a result, comprehensive case recordings are maintained for all notifications that are received.

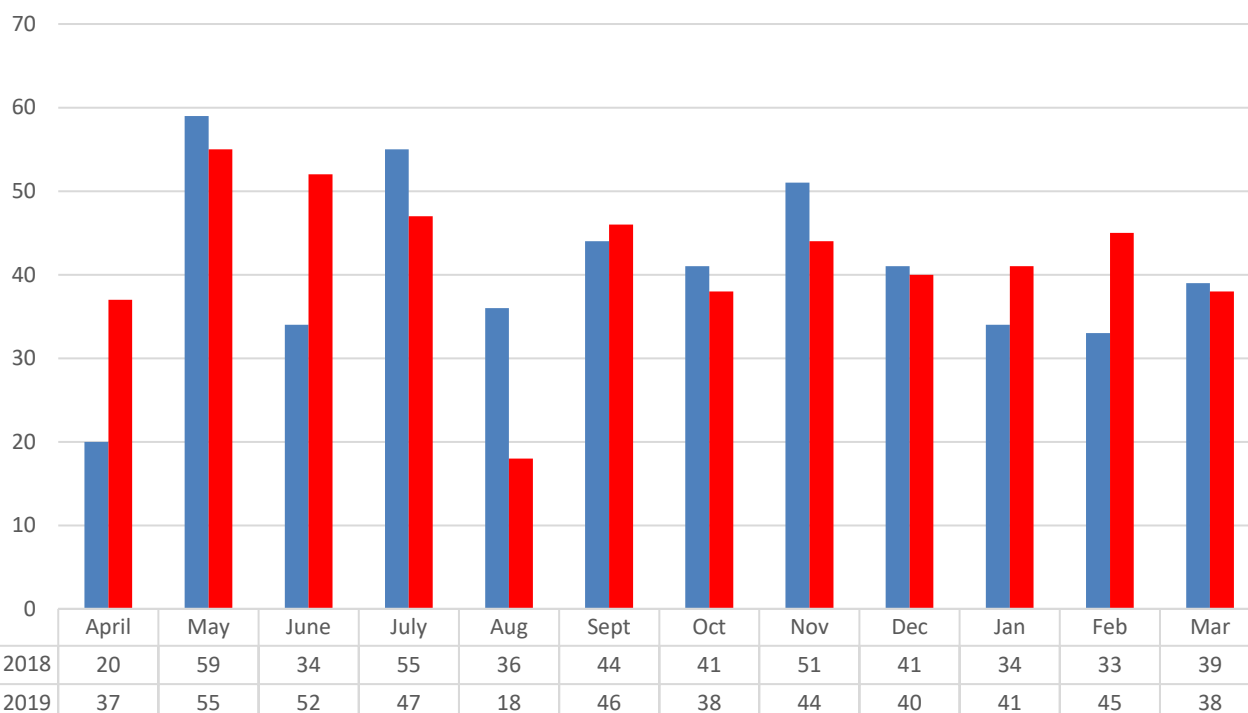
The high number of notifications also indicates that agencies / organisations are becoming increasingly familiar with the requirement to notify the LADO when there are concerns relating to the alleged inappropriate behaviour of employees / volunteers.

To deal with this increase, an attempt has been made to deal with capacity issues through a combination of measures. This includes the following:

- A robust application of the threshold to determine if the criteria to trigger the managing allegations procedure is met;
- Advice and guidance only being provided upon receipt of a completed Allegations Reporting Form (ARF);
- The remit of all Independent Safeguarding & Reviewing Officer now includes duty cover in the LADO's absence.

## 2.2 Comparison of Notifications

### Comparison of Notifications to the Previous Reporting Year



In comparison to the previous reporting year there were 5 months in 2018 / 2019 in which more notifications were received. There does not appear to be a pattern emerging whereby certain months are significantly busier.

The multi-agency safeguarding training – '*Introduction to Child Protection*' (one day) and '*Working Together*' (two days), continues to promote the managing allegations procedure and requirement to notify the LADO when there are concerns of inappropriate behaviour relating to employees / volunteers.

Notifications peaked in May although the numbers were slightly less than the corresponding period last year. There is no obvious reason for such a spike in numbers in this month.

The trend of notifications being lower in the school holidays - Easter, half-term and August holidays, continues.

Following the high volume of notifications in May the number received each successive month continues to fall until August which is the quietest month – 18 ARFs received.

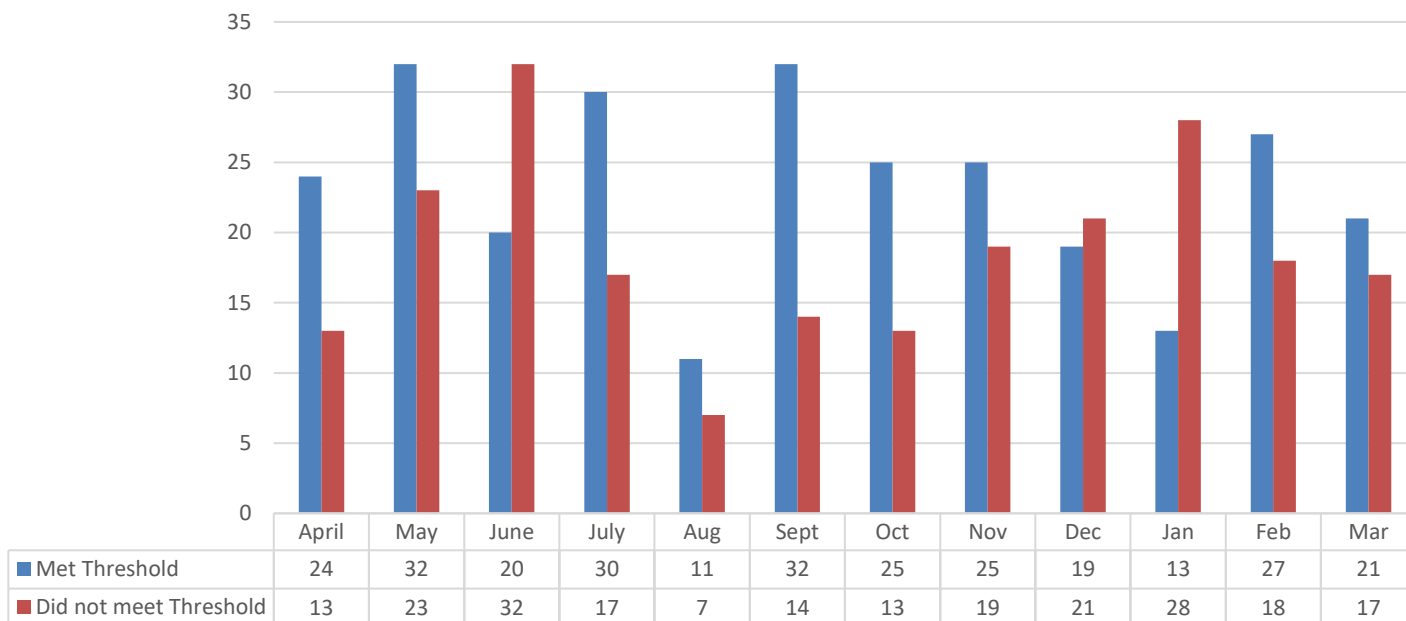
From September the number of notifications exponentially increased to 46 ARFs received and remained a consistent level for the remainder of the year.

There is insufficient evidence to suggest that there is an escalation in the number of professionals, working in the wider children's workforce, who may pose a risk to children. This is based on the number of notifications received which did not meet the threshold to trigger the managing allegations procedure which was 41% of cases closed.



## 2.3 Thresholds

### Notifications Meeting/Not Meeting the Threshold



The busiest month for receiving notifications was May during which well over a third received (41%) did not meet the threshold.

The average for the reporting year is 59% of total notifications received did meet the threshold to trigger the managing allegations procedure and 41% that did not.

Statistically the busier months – May, June and July, reflect the high number of notifications that do not meet the threshold. For example, 62% of notifications received in June not meeting the threshold. However, the volume of notifications received does not statistically correlate with high numbers of ARFs not meeting the threshold. For instance, in September 46 ARFs were received and only 30% did not meet the threshold.

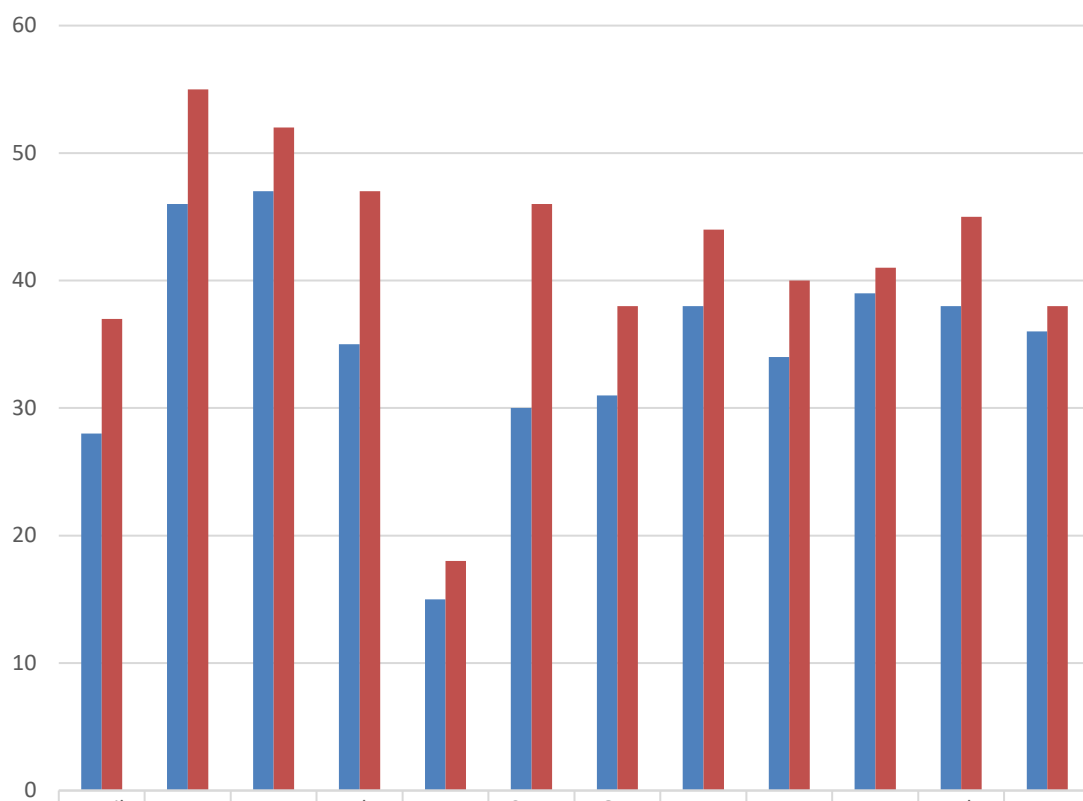
As noted above, the increase in notifications could be that there is a lack of confidence in managers, headteachers and professionals assessing if an allegation meets the threshold or not. It is worth noting the latest version of the ARF – providing the option to seek advice and guidance, is likely to increase the total number of ARFs recorded as not meeting the threshold.

It is acknowledged that there is a continuing need to provide training to managers, headteachers and professionals in the application of thresholds so

that it improves their understanding and confidence when interpreting allegations against the criteria.

## 2.4 Notifications Received in One Working Day

**The Number of ARFs received within One Working Day in Comparison to the Total Number Received Each Month**



■ ARFs received within one working day  
■ Total number of ARFs received

The statutory guidance requires agencies / organisations to notify the LADO of an allegation, that potentially meets the criteria to trigger the managing allegations procedure, within one working day.

The above graph demonstrates that at times agencies / organisations are not fulfilling the statutory requirement to notify the LADO within one working day.

Of the 501 notifications received during this reporting period 417 (83%) were received within one working day. This is an improvement of 8% from the previous reporting period.

There can be legitimate reasons for an allegation not being reported within one working day and therefore it is unlikely to ever reach 100%.

For instance, the organisation may choose to discuss the alleged incident with the child's social worker before notifying the LADO due to the young person having a history of fabricating allegations against staff.

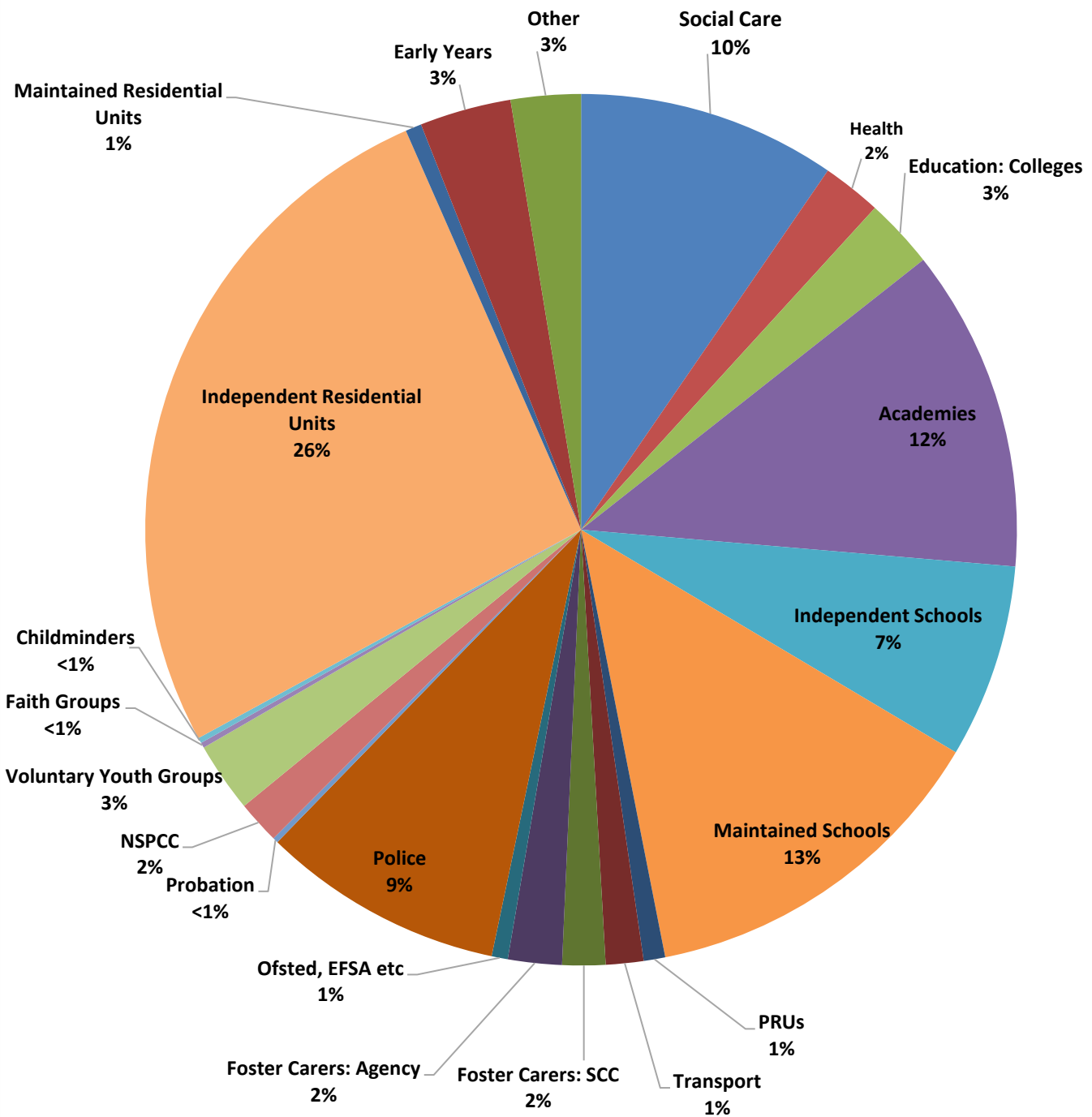
Additionally, it is recognised that on occasion delays can occur because of the organisation itself not considering an incident to meet the criteria whereas another organisation / agency involved with the child, who receives a disclosure from the young person, considers that it does and makes a notification.

Training provided to agencies and organisations reiterates the importance of this statutory timescale.

This statutory requirement will continue to be monitored with further promotion taking place at every opportunity.

## 2.5 Which Organisations are Making Notifications?

### Referrals by Organisation



### **2.5.1 Notifications from Education, Early Years Settings & Residential Settings**

The largest number of notifications received came from the education and early years providers which combined amounted to 38% of the total notifications received, this compares to 39% in 2017/18).

This was followed closely by notifications received from residential children's homes which combined amounted to 27% of the total notifications received, this compares to 24% in 2017/2018).

The amounts of time children spend in education and early years and / or who are accommodated in residential would explain the higher rate of notifications.

### **2.5.2 Notifications from all Schools**

The large number of notifications from the education sector can be accounted for by the following:

- It is a mandatory requirement for all children to attend an education provision. Therefore, it is in such settings – during term time, that they spend the majority of their day. Their daily interaction with adults statistically increases the likelihood of an incident occurring that meets the threshold.
- For some children attendance education is not a positive experience due to their own individual needs. When children are unhappy this can manifest in challenging behaviour. In such instances, the professional's ability to be sensitive to the needs of the young person, positively engage with them and competent to manage the situation creates an environment where there is the potential for allegations to be made.

### **2.5.3 Notifications from Independent Schools**

The number of notifications received from independent schools has decreased slightly from last year to 36 (7% of all notifications received) compared to 58 (12%) that were received in 2017 / 18. This is a de

The number of notifications for both independent schools and academies combined is approximately a 1/3<sup>rd</sup> higher than notifications received from maintained schools.

Often criticism is levelled at fee paying schools, and those not under local authority control, stating that there is insufficient focus on safeguarding with the reputation of the school i.e. avoiding bad publicity, being prioritised.

The statistics above do show a decrease in the total number of notifications received compared to maintained schools. However, the previous two reporting periods indicated that numbers of ARFs received compared to maintained schools was consistently high. In light of this slight decrease this statistic will be monitored throughout the year via the monthly performance report.

#### **2.5.4 Notifications from Residential Children's Homes**

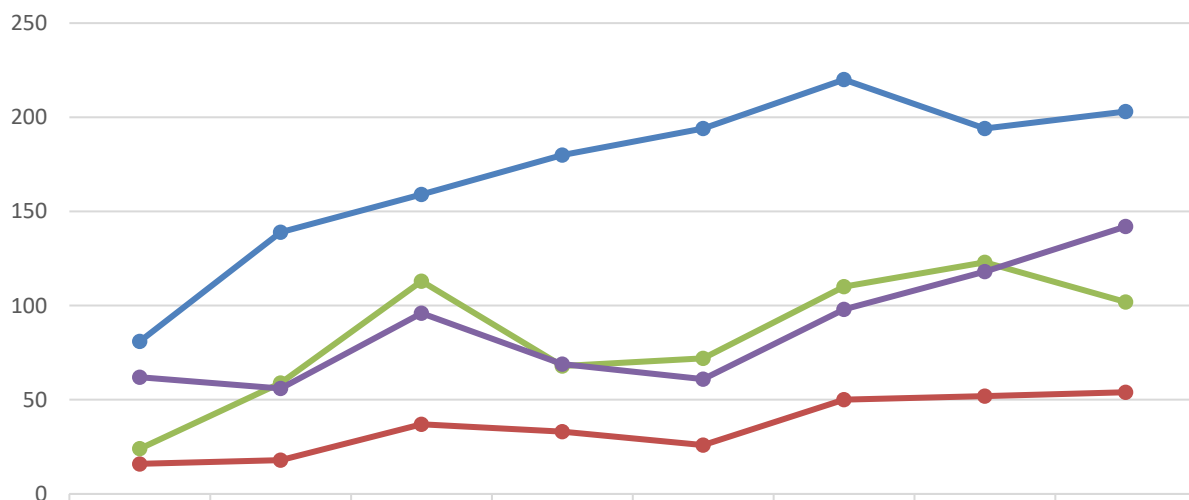
The residential sector is effective in making notifications with 135 (27%) of the total notifications received coming from this area. This is a slight increase from the previous reporting period - 117 (24%).

It is expected that the volume of notifications of residential care homes is high when the following factors are taken into account:

- For many children to be taken from their family home and placed into statutory care is not what they would wish for.
- As a result some will exhibit challenging behaviour as a result of their unhappiness and distress at being away from the family.
- The needs, often complex, that many children have.
- The potential issue of limited placement availability whereby decisions can be taken to place a child in a home without thorough evaluation of its ability to meet that child's needs.
- The pressure from Ofsted for all incidents of actual or potential inappropriate behaviour by staff to be notified to the LADO.
- Feedback from registered managers suggesting a greater confidence in the LADO service whereby they are quick to seek advice, guidance and support.

## 2.6 Types of Allegations

### Category of Allegations across Reporting Years



There has been a slight increase in the number of allegations relating to physical abuse being reported without any obvious reason.

Physical abuse remains the highest reported category of abuse given that it is the most easily identifiable of the abuse categories.

There has been a 17% decrease in the number of notifications relating to sexual abuse. Numbers of notifications received, relating to allegations of sexual abuse, were significantly less from residential children's homes, children's social care and independent schools. Conversely, there was a noticeable increase in notifications from the police.

Considering the national and local profile on child sexual abuse this decrease is surprising.

The trend of a yearly incremental increase in neglect / inappropriate behaviour continues. Neglect in this instance being an employee's failure to exercise their duty of care that has harmed or may have harmed a young person.

There has been negligible increase in incidences involving emotional / verbal abuse.

## **Physical Abuse**

Since 2014 / 2015 there has been a year on year increase in the number of notifications relating to *physical abuse*. Although there was a 13% decrease last year the trend is again showing an increase, with there being 4% more notifications of physical abuse than last year.

## **Emotional Harm**

In relation to *Emotional harm* there has been a 4% increase in the number of notified incidents which is similar to the % increase last year.

## **Inappropriate Behaviour / Neglect**

In relation to *Inappropriate behaviour / neglect* there was another 20% increase continuing the trend from last year.

## **Sexual Abuse / Child Sexual Exploitation (CSE)**

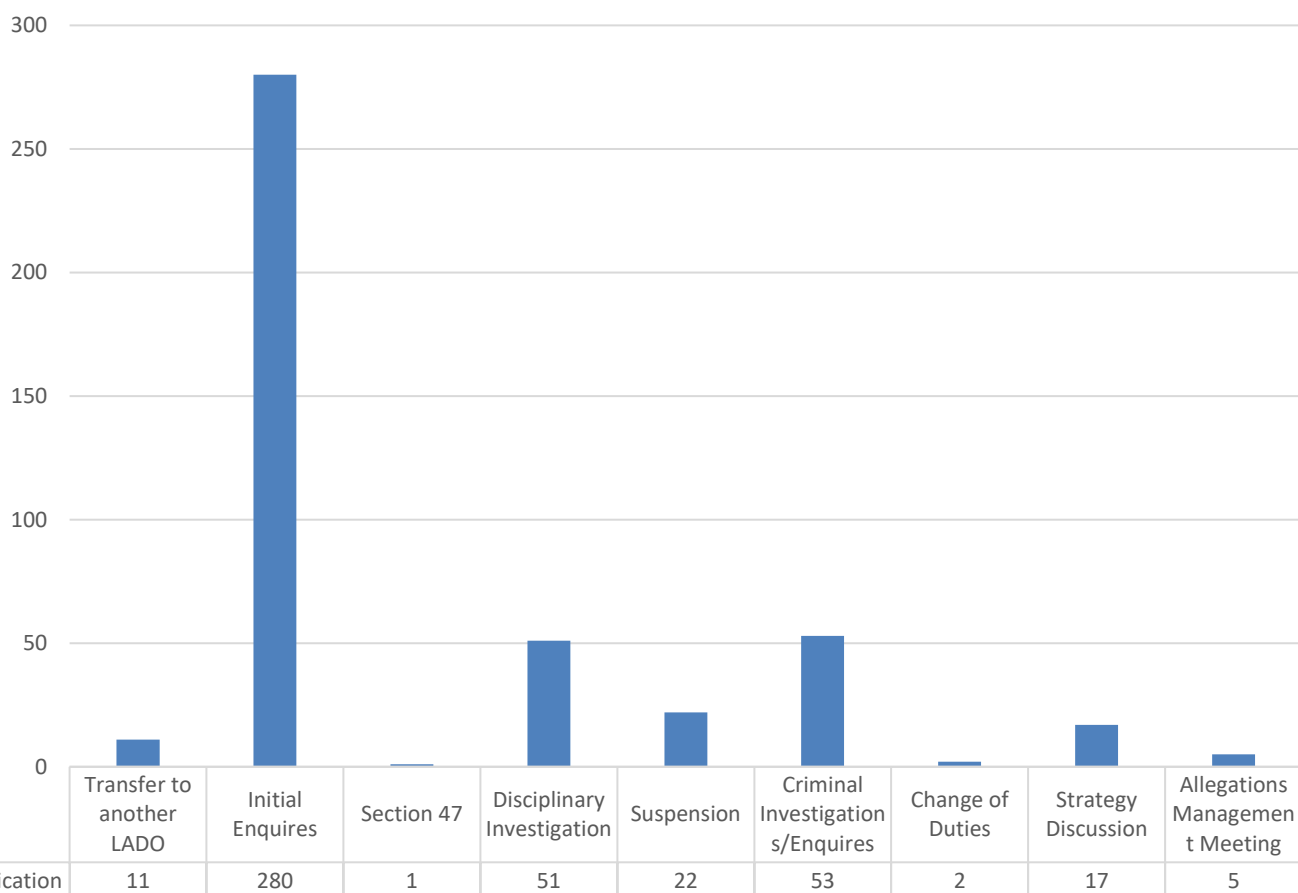
In terms of *Sexual Abuse*, following a 23% increase in notifications last year this reporting year shows a 17% decrease.

In this reporting year there were no CSE notifications in relation to people working in a position of trust. This continues to be monitored with individual sexual abuse being considered against the three elements that defines this form of abuse.



## 2.7 Responses to Notifications

### Initial Actions Taken



#### 2.7.1 Transfer of Notifications (Transfer to another LADO)

Generally, a notification is transferred to a different local authority LADO when it is deemed that that the adult of concern i.e. the presenting risk, works in its area. Further consultation takes place between the respective LADOs to ensure a comprehensive handover of actions.

This protocol has been established and agreed nationally by the National LADO Network.

During this reporting year 11 notifications were transferred to another LADO compared to 12 in the last reporting year.

### **2.7.2 Section 47 & Strategy Discussions**

There were 17 strategy discussions because of there being reasonable cause to suspect a child/ren had suffered, or was likely to suffer, significant harm.

In one of these strategy discussions only one led to a decision to undertake child protection enquiries (section 47, Children Act 1989).

### **2.7.3 Investigations by the Employer (Disciplinary investigations)**

Where the threshold is met i.e. one of the three criteria within the managing allegations procedure, the LADO Service advises the employer of the need to formally investigate the allegation. It is normally expected that this would be under the employer's disciplinary procedure.

There were 51 notifications that were formally investigated under the employer's disciplinary procedure.

### **2.7.4 Suspension**

The statutory guidance for schools – '*Keeping Children Safe in Education*' (2016) and for all other organisations the guidance within the South West Child Protection Procedures, states that suspension should not be automatic. It encourages other options to be considered before a decision is taken to suspend e.g. re-deployment.

For many employers however, they will defer to their own disciplinary policy which for many organisations state that a decision to suspend should be taken when the allegation indicates an act of potential gross misconduct has been possibly committed.

In this reporting year 22 notifications resulted in the individual of concern being suspended.

### **2.7.5 Criminal Investigations**

Consultation will always take place with the Police when notifications indicate that a criminal offence has potentially been committed against or related to the child. This liaison with the Lighthouse Safeguarding Unit (LSU) ensures that appropriate decisions are taken to determine if the criminal threshold is likely to be met and if so ensures that the case is allocated to the relevant inspection team.

There were 55 notifications that resulted in criminal enquiries or investigations being undertaken by the Police. This is a slight decrease from the 63 investigations last year.

### **2.7.6 Change of Duties**

In only 2 notifications, rather than to suspend the member of staff alternative working arrangements were agreed. This included a change of work base or role during the course of the investigation.

### **2.7.7 Allegations Management Meetings (AMM)**

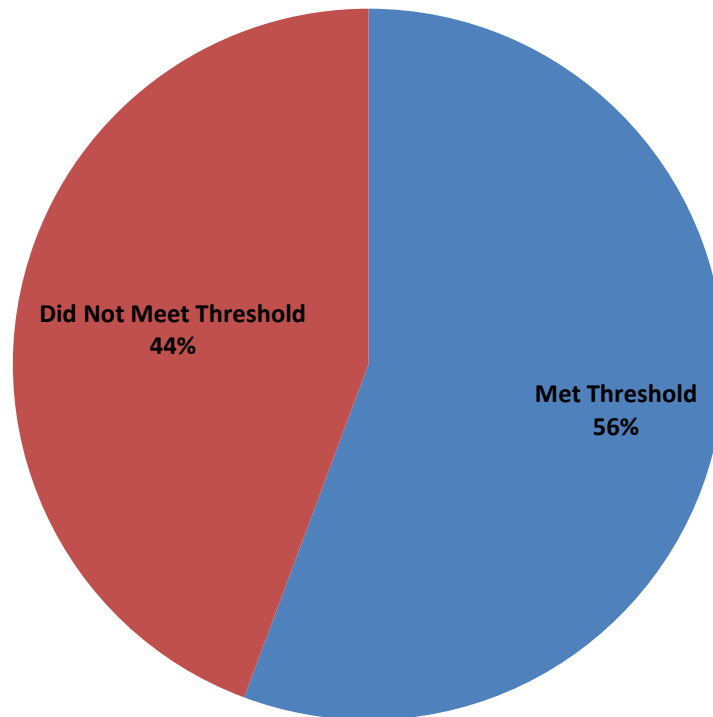
When it is determined that the threshold for Children's Social Care is not met i.e. reasonable cause to suspect a child has suffered, or is likely to suffer, significant harm, there may be a need to convene an AMM.

Generally, this will be those notifications that are complex and require a meeting with the police and the employer to share information and to agree respective actions.

In the current reporting year 5 AMM were convened.

## 2.8 Number of Allegations Not Meeting Criteria

### Total Percentage of Notifications that met/did not meet Threshold



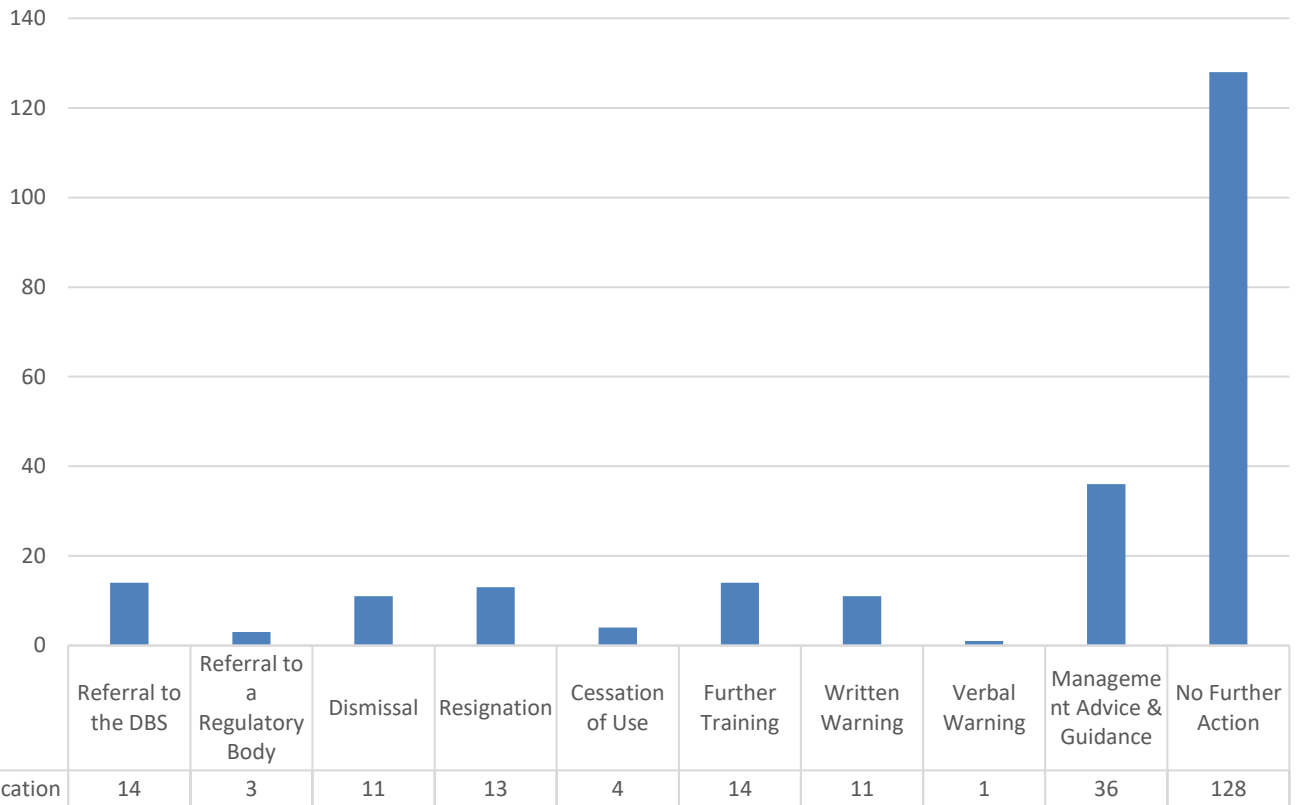
168 (35%) notifications to the LADO were deemed not to meet the criteria for triggering the managing allegations process. This compares with 24% in 2016 / 2017.

This number represents a significant investment in time in evaluating notifications, including the need to seek further clarification, before determining that the threshold is not met.

An example of this is a parental complaint that the school is failing to address bullying behaviour towards their child. Whilst the emotional impact on the child can be harmful it is as a result of the possible inadequacy of the schools overall safeguarding arrangements – particularly its bullying policy, supervision and pastoral arrangements, rather than one individual being culpable for the harm being experienced by the child.

## 2.9 Concluding Actions

### Concluding Actions Taken



### 2.9.1 Ending of Employment / DBS Referrals

When comparing the total number of dismissals / resignations (24) to the number of referrals to the DBS there is a considerable contrast.

This can be attributed to certain criterion to make a DBS referral not being met i.e. the employer has withdrawn permission for the employee to work in a regulated activity AND the individual has either 'engaged in relevant conduct' or 'satisfied the harm test'.

Not all employees are working in a regulated activity and in such cases a decision to dismiss will not meet the criteria to make a referral.

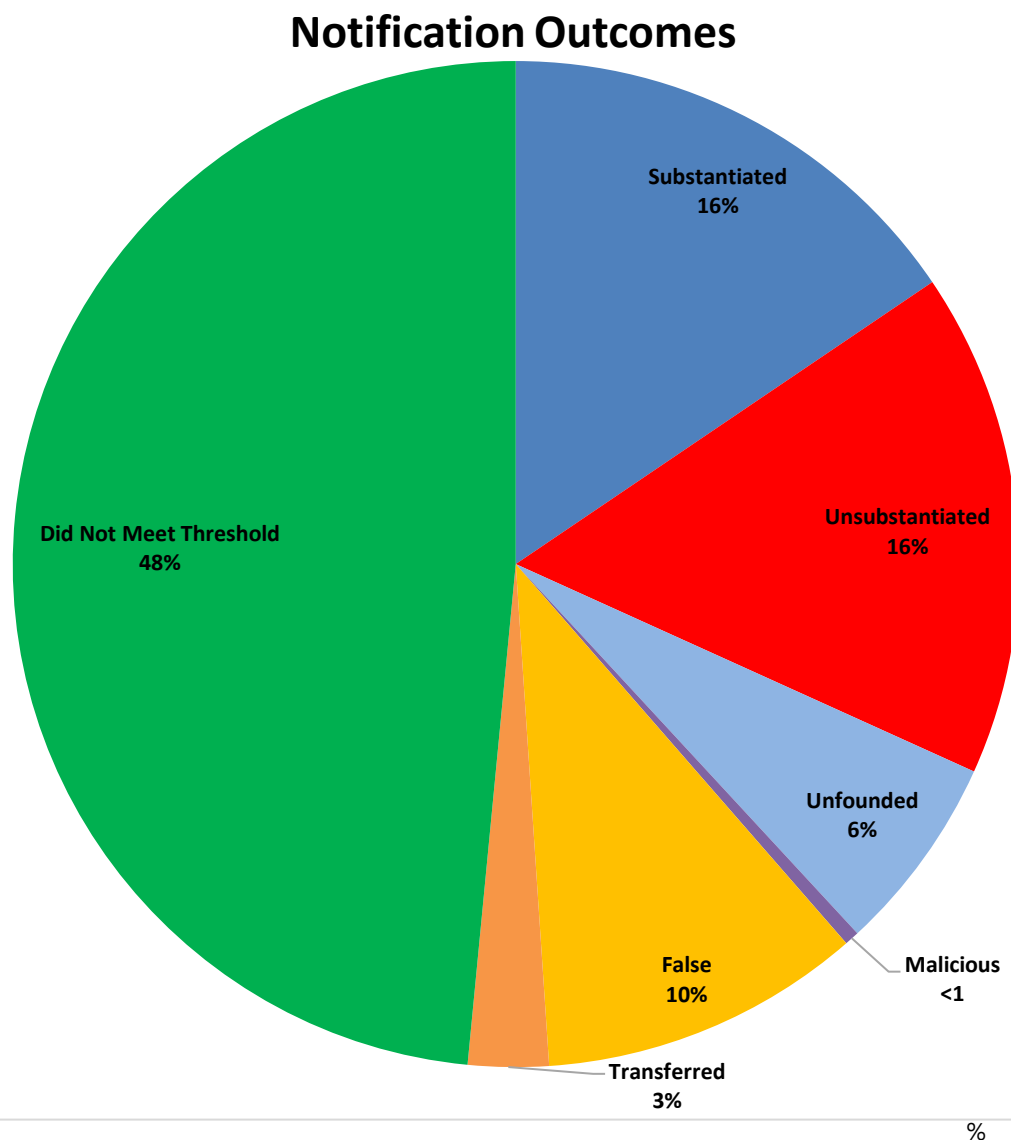
## 3.0 Outcomes of Allegations

### 3.1 Department for Education Definitions

The Department for Education outcomes to be recorded when notifications are closed, including definitions and numbers / percentage of notifications closed under each outcome, are listed below.

- **Substantiated:** there is sufficient evidence to prove the allegation (66 [13%] of cases);
- **Unsubstantiated:** there is insufficient evidence to prove or disprove the allegation. The term, therefore, does not imply guilt or innocence (69 [14%] of cases);
- **False:** there is sufficient evidence to disprove the allegation (44 [8%] of cases);
- **Malicious:** there is sufficient evidence to disprove the allegation and there is a deliberate act to deceive (only two notifications had this recorded outcome).
- **Unfounded:** this is defined as there being insufficient evidence or proper basis which supports the allegation being made. It might also indicate that the person making the allegation had misinterpreted the incident or was mistaken about what he/she saw or was not aware of all the circumstances (27 [5%] of cases).

### 3.2 Breakdown of Outcomes



- The number of *substantiated* allegations remains at 16% albeit more notifications have been received in this reporting year.
- There has been a 5% decrease to 16% in the total number of *unsubstantiated* allegations (21% in 2017 / 2018). This percentage decrease corresponds with last year when a similar decrease occurred.
- Less than 1% of total notifications received resulted in an outcome of *malicious*.
- The number of *false* allegations has decreased by 4% from 14% in 2017 / 2018 to 10% in this reporting year.

- The number of 'Unfounded' allegations was 27 (6%) of cases which is exactly the same as the last reporting year.

### **3.3 Actions Taken by the Employer**

#### **3.3.1 Recording of Concluding Actions**

It should be noted that the recording of concluding actions by employers can lead to double or even multiple counting for individual notifications. For instance, a substantiated allegation of sexual abuse perpetrated by a teacher can lead to the following recorded actions:

- Dismissal;
- Refer to the regulatory body;
- Refer to the Disclosure and Barring Service;
- Criminal Conviction.

Even in less serious cases there may be a need to record several concluding actions. For example, in the case of foster carers an allegation that the carer handled the challenging behaviour of the child in placement inappropriately led to the following actions:

- additional supervision;
- refresher training;
- management advice.

### **3.4 Initial Actions**

#### **3.4.1 Criminal investigations / enquiries**

Of the notifications that resulted in criminal investigations / enquires (53) none resulted in a conviction.

There are a number of on-going criminal cases carried forward from the last reporting year that may possibly lead to convictions. Once concluded these figures are included in the next reporting year.

#### **3.4.2 Formal Action Taken by Employers Following Investigation**

Of those cases where there were sufficient grounds to pursue formal procedures - disciplinary investigation (n.51, 10%), the following outcomes are recorded:

- In 11 cases a decision by the employing organisation to *dismiss* the employee.



- In 11 cases a decision was taken to issue formal *written warnings* to the respective employees.
- In 14 cases the employer has provided *training* to the employee.
- 36 cases resulted in *management guidance* being provided to the individuals concerned. This includes those cases where the outcome is recorded as unsubstantiated and the employee was reminded of the required standards of conduct expected by the organisation and the need to comply with its policies and procedures.
- In 14 of these cases a referral was made to the *Disclosure and Barring Service* (DBS) for a decision to be made about whether the individual should be barred or restricted from working with children and young people in the future. Current legislation prevents the DBS from informing the local authority as to what decision it takes on referrals made. It is not possible to confirm the conversion rate of referrals to decisions to ban or prohibit the individual from working with children.
- In 4 cases the individuals were either employed through an agency or providing services on a self-employed basis and their work with the organisation was *ceased*.
- In 3 cases a referral was made to the relevant *Regulatory Body* e.g. National College for Teaching & Leadership (NCTL); Health & Care Professions Council (HCPC).

### 3.4.3 Resignations

The statutory guidance for schools – '*Keeping Children Safe in Education*' (2018), and for all other organisations the guidance within the South West Child Protection Procedures, requires that allegations are investigated even if the individual has resigned. It acknowledges that this can be difficult given the employee may have served their notice and left their employment.

Nonetheless, the guidance states that the process of seeking a response from the individual, recording the allegation, collating and considering any supporting evidence and reaching a judgement should still happen.

This process ensures that safeguarding concerns are referred to where future reference requests are received by the previous employer.

In 2018 / 2019 13 staff members *resigned* prior to or during the process of an allegation being investigated. The allegations were investigated by the employer and the following conclusions reached:

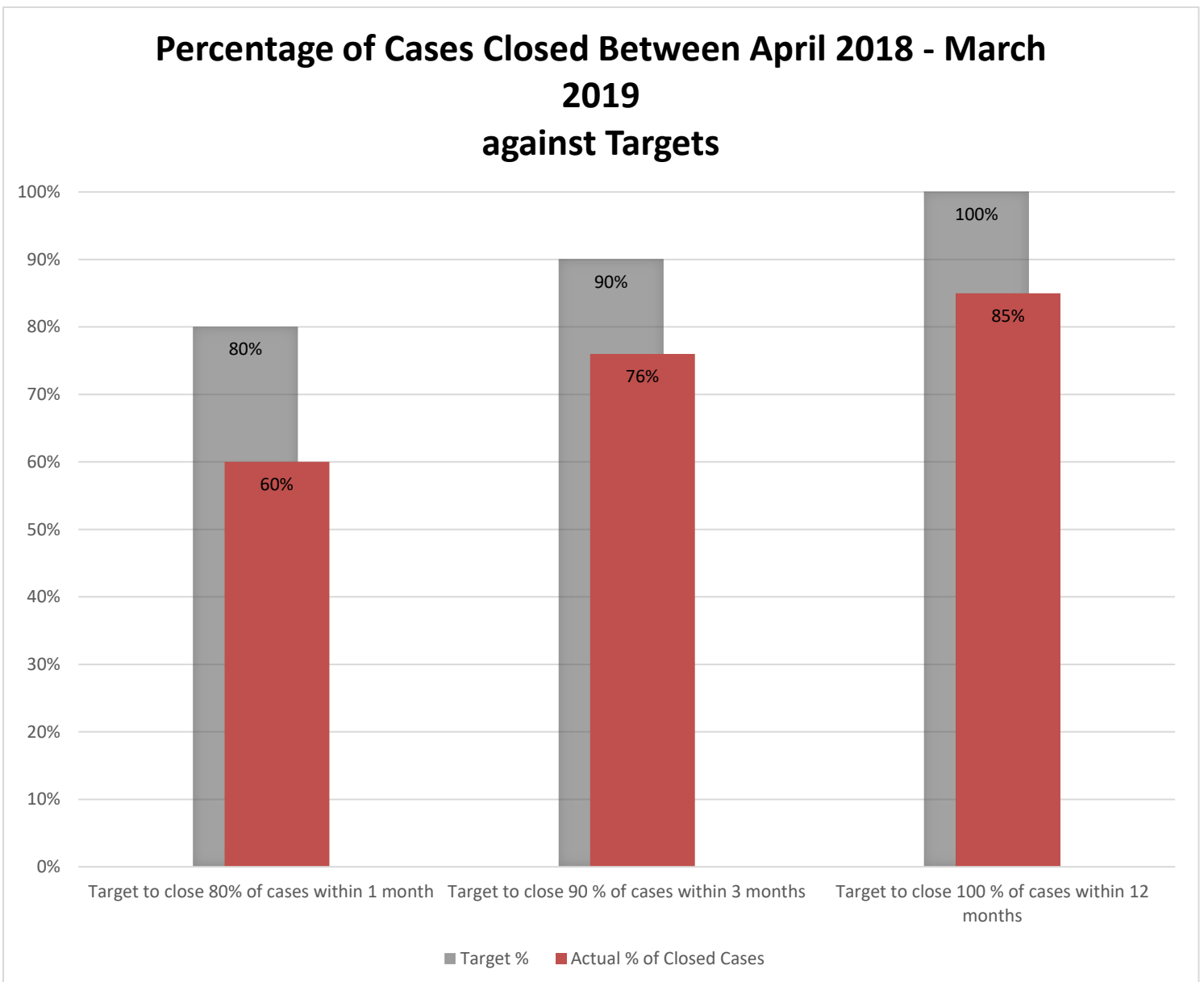
- The outcome in eleven of the allegations the decision taken was that the allegations were substantiated.
- In four of the eleven cases a decision to dismiss would have been taken had the individual not resigned.
- In five of the eleven cases a referral was sent to the Disclosure & Barring Service.
- No cases required a referral to the relevant regulatory body e.g. National College for Teaching and Leadership

### 3.5 Timescales to Close Notifications

The statutory guidance requires that all notifications are resolved as quickly as possible consistent with a fair and thorough investigation. To this end, a key aspect of the role of LADO is to be involved in the management and oversight of all notifications ensuring that agencies and organisations involved avoid unnecessary delays.

The following target timescales outlined in the statutory guidance for school notifications are also used for all notifications from across the children’s workforce. These timescales are useful in measuring the effectiveness of notification being closed expeditiously:

- A. 80% of cases to be resolved within **one** month.
- B. 90% to be resolved within **three** months.
- C. All but the most exceptional cases to be closed within **twelve** months.



### 3.5.1 Limiting Factors

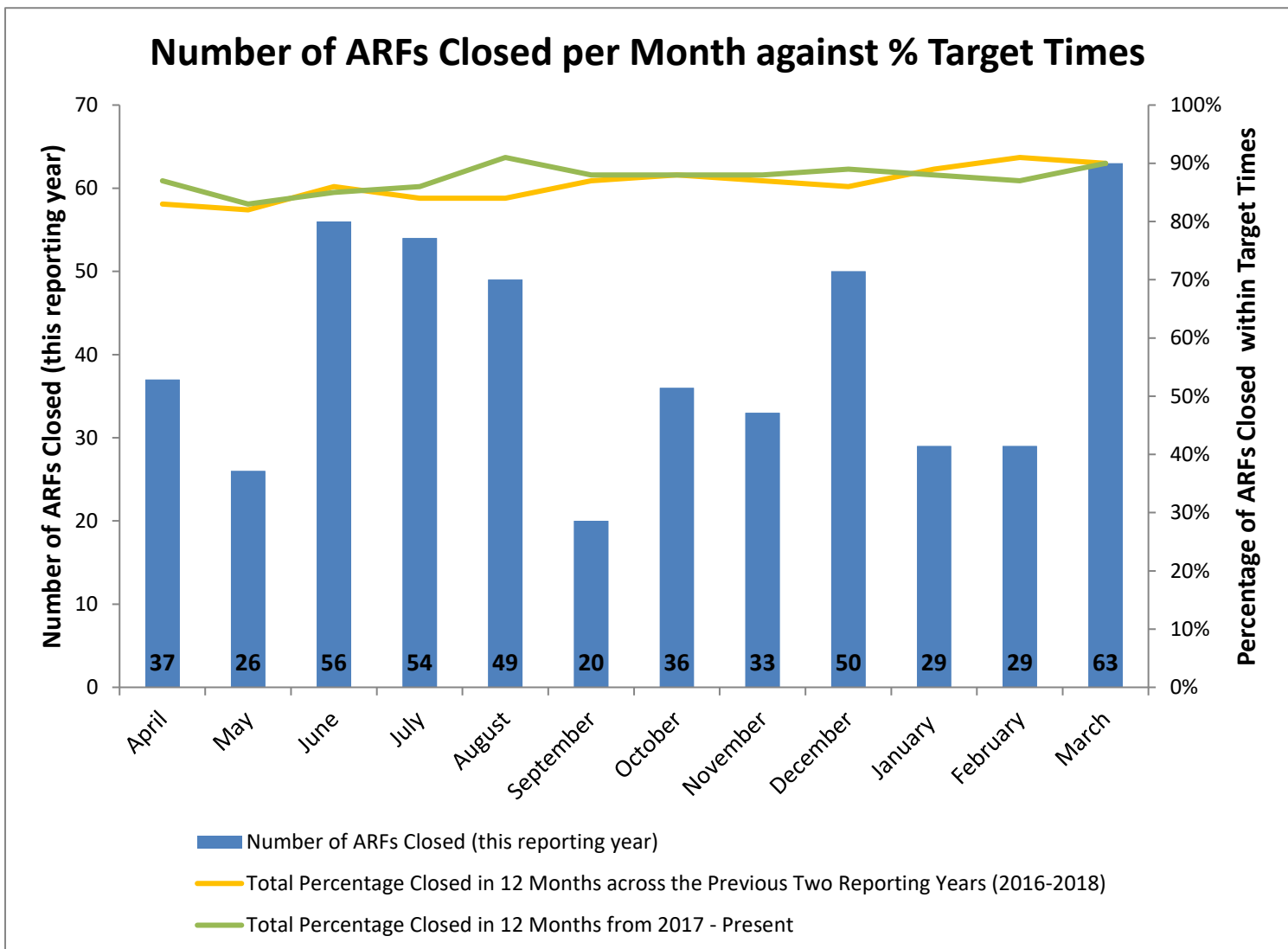
There are a number of factors that make these targets challenging including:

- The length of time a case may take to work through the criminal justice process to conclusion.
- Employers awaiting the outcome of a criminal investigation before formally investigating the concerns under its disciplinary procedures.
- Practical considerations such as the unavailability of people for interview including witnesses to an incident due to shift patterns; holidays; sickness.

### 3.5.2 Improvement

Monthly performance reports – see Appendix A, demonstrate a steady improvement in all three targets being met.

This upward trend in the closure rates of notifications received is outlined in the following graph.



## 4.0 Demographics

The notification form (Allegations Reporting Form - ARF) requires the notifier to provide certain information relating to gender, age, ethnicity and disability of the child, where one is identified, and the adult of concern.

Although the gender is requested for both the named child and the adult of concern this statistic is only recorded for adults.

Of the 501 notifications received the gender of the adult of concern was:

226 – females

267 - males

The number of males being reported is predominantly higher than females which is important to note given the majority of the children's social care workforce is anecdotally female. In the absence of any research it can only be speculated as to the possible reasons for this.

In terms of age, the date of birth is not always known and is not currently expressed statistically as an age profile. For instance, for adults of concern it might be expected to see an age profile range covering 18 - 24-yrs; 25 – 34-yrs; 35 – 44-yrs; 45 – 54-yrs; 55 – 64-yrs etc.

In relation to children and young people reported as being harmed by people working with them, the following ethnicity categories are recorded:

- Asian / Asian British – Other Asian – 1
- Black or Black British – African – 3
- Black or Black British – Caribbean – 3
- Black / Black British – Other – 2
- Chinese – 1
- Mixed – Other Mixed Background – 3
- Mixed – White & Asian – 1
- Mixed – White & Black African – 1
- Mixed – White & Black Caribbean – 4
- White – British – 311
- White – Other Cultural Backgrounds – 10
- White – Other European – 7
- Other – 2

In relation to adults of concern the ethnicity recorded is the following:

- Black or Black British - African – 3
- Black or Black British – Caribbean – 2
- Black / Black British – Other Black – 1
- Mixed – Other Mixed Background – 2

- Mixed – White & Black Caribbean – 1
- White - British – 321 (64%)
- White – Irish – 1
- White – Other Cultural Backgrounds – 4
- White – Other European – 23 (5%)
- Other – 3

For both children and adults of concern just under half of all ethnicity categories (22 in total) are represented in these statistics.

The predominate statistic relates to people identifying as White – British with the only other noteworthy statistic relating to European Community citizens.

According to the 2011 population census 94.6% of the Somerset population identified as being White – British. This is comparable to Somerset neighbouring authorities but is considerable higher % than the England and Wales average (80.5%).

In the remainder of the ethnic categories just over 2% identified as Black, Asian, Minority Ethnic (BAME). This figure is comparable to the overall population of Somerset which is recorded in the 2011 population census as 2%.

Of the 501 notifications received, the ethnicity was recorded for 349 children. Of this figure, 89% (n.311) of children and young people identified as White British and 5% (n.18) identifying as BAME. This is twice the proportion of the overall BAME demographic for the total population of Somerset. Without undertaking research into this the author is unable to comment further.

In 30% of notifications received the ethnicity of the child was not known, provided or was not relevant as the victim was identified as adult e.g. non-recent allegations of abuse.

In terms of disability information, for children reported, 54 (11%) notifications recorded that the child had a disability.

This represents a considerable decrease in the numbers of children reported as having disability from the previous reporting year which was 24%. This is contrary to national research which evidences that children with disability are more vulnerable to abuse.

The information provided is not qualitative and therefore does not analyse the nature of the young person's disability.

In relation to adults reported, only 5 (1%) individuals were classed as having a disability; however, 110 (22%) cases the information was not known to the notifier and in 77 (15%) cases the information was not provided.

## **5.0 Service Development**

### **5.1 Progress on Priorities set in 2017/18**

#### **Analysis of the high numbers of notifications not meeting the threshold**

In 48% of notifications received none of the three criteria – the threshold, to trigger the managing allegations procedure was assessed by the LADO as being met.

A quality assurance audit was carried out in which a sample of notifications, closed based on not meeting the threshold, were reviewed. Given the high number of notifications closed as not meeting the threshold, this audit was seeking to analyse the rationale behind the LADO's decision.

In all cases reviewed the auditors supported the LADO's decision that the matter did not meet the threshold.

Upon further analysis of notifications not meeting the threshold it was decided to amend the notification form and re-issue to agencies / organisations. This revision has introduced the ability to submit a notification (without details of the adult or child) whereby the notifier does not necessarily feel that three criteria are met but is seeking general advice and guidance from the LADO.

The number of notifications submitted (and subsequently closed) as '*Advice & Guidance*' currently comes under the umbrella of notifications closed as not meeting the threshold, thereby inflating this figure. It is planned next year to record this as a separate statistic so that it is possible to differentiate between the two outcomes.

The year-on-year increase of notifications, including those not meeting the threshold, continues to create capacity issue. Each notification received requires individual logging and assessment. The time devoted to this can be extensive. Additionally, the collation and clarification of information required to reach a view that the threshold is not met is often time consuming.

As reported last year, this problem continues to be exacerbated by the pressure from Ofsted on regulatory settings to send notifications on all

incidences of physical contact despite a judgement by the organisation that their staffs have acted in accordance with policy, procedure and training requirements.

Feedback has been given directly to Ofsted challenging how its inspectors interpret the application of the managing allegations procedure. Throughout the year briefings have taken place with managers / Headteachers to improve their confidence in interpreting incidences and applying the criteria.

### **Increase the number of notifications received from the Police/Health**

Discussions have taken place with the Police Professional Standards Unit to ensure that it is familiar with the managing allegations procedure and the need to notify the LADO Service should an incident involving an officer meets the criteria.

HR practitioners in sompar NHS Foundation Trust and Somerset & Taunton NHS Foundation Trust have received a briefing on the application of the managing allegations procedure and the need to notify the LADO Service.

To date this has not seen any change in the number of notifications received.

### **Notifications received within one working day**

Through on-going promotion and publicity to agencies / organisations there is an overall improvement in notifications received in one working day.

417 (83%) notifications were reported within one working day compared to 75% in the last reporting year.

There can be legitimate reasons for notifications being reported within one working day as referred to in section 2.4.

### **Completion of a written business process for the managing allegations procedure**

The first draft of this has been completed and is being quality assured before the final version is produced.



## **Improve the timescales for closing notifications received**

Over a two-year period 90% of notifications are closed within 12 months.

It is unlikely that 100% of cases will ever be closed within this timeframe. This is for several reasons including the length of time criminal investigations can take and capacity issues to follow up open cases to confirm outcomes and actions taken.

## **Producing publications**

Issues with capacity and conflicting work demands has led to a decision being taken to move this action into the current reporting years' list of priorities.

## **6.0 Other Developments**

### **6.1 Promotion of the Managing Allegations Procedure**

The promotion of the managing allegations procedure to all agencies / organisations continues.

Specific work has been undertaken with attendance at Designated Safeguarding Leads (schools) and registered managers (children's homes) forums.

The importance of promoting the managing allegations procedures extends to children, parent(s), carer(s), professionals and volunteers involved when an allegation of inappropriate behaviour is made so that all parties understand the processes that are followed and the support available.

### **6.2 Safeguarding Advisors Forum (SAF)**

The Safeguarding Advisors Forum continues to meet on a quarterly basis and is administered and chaired by the LADO.

This forum meets to share knowledge, expertise, best practice and training resources amongst safeguarding leads from early years, education, training, district councils, placements team and transport.

This enhances the advice and support provided by Somerset County Council and District Councils safeguarding representatives to safeguarding leads of affiliated organisations. This promotes the joint responsibility of partnership working to keep all Somerset children, particularly those identified as vulnerable e.g. children who are looked after, safe.

### **6.3 Archiving Hard Copy Files**

Following a concerted effort over the past 18 months all remaining hard copy files for the LADO Service have been moved from storage at the Bridgwater office – taking up valuable storage space, to the archiving store at the Somerset Heritage Centre.

Once the moratorium on the retention policy, set by the Independent Inquiry into Child Sexual Abuse, is over, the service will be in a stronger position to be compliant with data protection requirements to delete files after certain time periods.

### **6.4 Regional & National Networking**

The LADO continues to attend the regional South West LADO group which has input into the National LADO Network (NLN) that has established agreed operating principles to aid in consistency of approach for LADOs across the country.

- The NLN is a representative group of all the LADO regions across England & Wales. It has established an executive forum, supported by working groups to create national standards, joint protocols e.g. to deal with cross boundary issues, promoting the managing allegations procedures to key agencies and organisations e.g. DfE. It has forged links with the Independent Inquiry into Child Sexual Abuse led by Alexis Jay.
- The South West regional group continues to develop with its prime focus to ensure that practice and processes between South West LADOs are consistent and complies with statutory guidance and the South West Child Protection Procedures. Additionally, the forum is used to share information, best practice and lessons learnt from each other's professional experiences as well as learning from serious case reviews. This forum enables the identification of training needs and input into policy development at a local and national level.

A business plan has been created that oversees the development of the LADO (aka Designated Officer) role – see Appendix B

### **6.5 Safer Recruitment Training**

On behalf of the Somerset Safeguarding Children Board the LADO has been commissioned to deliver three times a year the nationally accredited Safer Recruitment Training course.

### **6.6 Headteachers Induction**

Delivery of presentation at the annual induction organised for new appointed Headteachers.

## **7.0 Emerging Themes, New Issues & Challenges**

One of the challenges outlined in *'The Somerset Plan for Children, Young People and Families'* (2019 – 2022) is Contextual Safeguarding.

Contextual safeguarding recognises that children and young people form relationships outside their family. This includes relationships within their neighbourhood, schools and online. Occasionally such relationships can feature violence and abuse.

Given these relationships occur outside the family home, parents and carers have little influence over these relationships and young people's experiences of extra-familial abuse can undermine parent – child relationships.

Sometimes these contexts involve people who work with them.

The LADO service has a significant role in working with children's social care and the police in identifying and tackling exploitation by those working in a position of trust with children and young people. The importance of this partnership working is reflected in this year's action plan where areas of work will focus on promoting the managing allegations procedure – the creation of pamphlets for those involved in the process including children and their parents; supporting managers & professionals to understand the criteria and

to make timely and appropriate notifications. Additionally, working closely with Ofsted, the ESFA, regulatory bodies and colleagues within both the Placements Team and the newly formed safeguarding education service to identify organisations that require intervention to protect children who may be being abused by those working within such environments. This partnership working enables the LADO Service to understand the efficacy of safeguarding systems and practices within these organisations.

### **Action Plan for 2018 & 2019 – see Appendix A**

From the emerging themes an action plan has been produced.

Anthony Goble  
Local Authority Designated Officer  
May 2019