Kingston and Richmond
Safeguarding Children Partnership

Report of Kingston and Richmond Safeguarding Children Partnership Scrutineer's Report
Neglect Deep Dive - August 2025

1. Introduction

This report is presented to the Kingston and Richmond Safeguarding Children Partnership (KRSCP) Wider Senior Executive Group (WSEG) and details the findings of the scrutiny of the deep dive activity, undertaken by the Kingston and Richmond Safeguarding Children Partnership Independent Scrutineer.

The deep dive was agreed by the WSEG and focused on children who have experienced neglect. This theme closely aligns to one of the partnership's priorities, as outlined in the KRSCP Business Plan 2024-2026 and responds to recommendations from local reviews where children experienced neglect.

The terms of reference for the deep dive provide an outline of the methodology adopted. (Appendix 1).

2. The Deep Dive Process

The deep dive was a significant piece of work undertaken by the partnership and included an in-depth audit of the documentation that related to 8 children living in either Kingston or Richmond. All partners were asked to complete a single agency chronology for the child they had provided services to. The responses were then amalgamated into a multi-agency chronology and shared with a request for partners to complete an audit of their involvement with each child/young person, highlighting what was working well and what the current worries from their perspective were. They were also encouraged to reflect learning both for their own agency, and the wider partnership.

A total of forty-six completed audits were received. Three partners did not submit audits, Kingston Hospital, Kingston housing, and Richmond housing; however, all three did submit chronologies. GP response was good with seven returning chronologies, and five completing audit forms.

Following the audit activity, moderation meetings were held. The completed audits were shared with the moderation invitees prior to the meeting taking place.

The moderation meetings sought to understand the impact of current practice in relation to neglect, and to identify key themes and any learning to take forward. Agencies involved in the moderation sessions included the police, children's social services, relevant health services, Kingston housing, and education.

3. The Scrutiny Process

The Independent Scrutineer was provided with a range of documents, detailed below in section 4. These were read and triangulated against the emerging evidence from the other approaches used within the deep dive. The two moderation meetings were attended by the Scrutineer.

Part of the methodology used for this deep dive was for the scrutineer to engage with frontline practitioners and to hear children and young people's views. The Scrutineer facilitated a multi-agency event with practitioners during the period the deep dive was being planned, which followed a rapid review where neglect was a feature. This offered the opportunity to engage with and hear the voice of practitioners.

The Scrutineer and Deputy Partnership Manager met with the young Scrutineer to explore the approach to hearing the voice of children and young people.

Following this a meeting took place, which was facilitated by the young Scrutineer, to enable the Scrutineer to hear the experience of a young person who had received services from a range of professionals as the result of her experience of living in a home where she experienced neglect.

The Scrutineer would like to acknowledge the braveness of the young person in sharing their experience and in making such a phenomenal contribution to the work of the partnership in this important area.

4. Key Documents read by the Scrutineer to triangulate the findings of the deep dive

In triangulating the audit findings, the Scrutineer reviewed the following key documents:

- The completed audits
- The Deep Dive Child Neglect Multi-Agency Audit Moderation Report- April 2025
- South West London Joint Child Neglect Strategy 2025
- KRSCP Rapid Review Reports
  - [redacted] - Kingston - January 2024
  - [redacted] - Kingston - July 2023
  - [redacted] - Richmond - July-August 2024 plus practitioners' event summary
- LCSPRs/SCRs
  - SCR Child O 2017
  - CSPR Child V 2021/2022
  - Local learning review concerning neglect
- London Rapid Reviews Analysis Report (2023-2024)
- KRSCP Education Neglect guidance June 2025
- KRSCP neglect audit report 2020
- Training summary

5. Key Learning and themes emerging from the deep dive

The key themes and learning identified and agreed by partners who participated in the deep dive were as follows:

➢ **Three generational genograms**

The potential value of using three generational genograms when engaging with families, an approach that would reflect Social GRRAAACCEEESSS (Burnham 2012).

- **Home Environment**

A better understanding of hoarding behaviours and chronic disorganisation might have supported practitioners more effectively.

- **Animals in family homes**

Recognition of the challenges social workers face in assessing animal/dangerous dog-related risk.

- **The role of the Fire Brigade**

The need to provide high-quality referrals to the London Fire Brigade, including details of child safeguarding concerns

- **Engagement with housing partners**

The crucial role housing has in safeguarding children There were challenges engaging housing in the deep dive.

- **Parental Factors**

  - The correlation between ADHD, poor mental health, and trauma in some of the adult carers.
  - Connection between poor mental health, domestic abuse, and substance misuse.
  - Absent fathers with a lack of knowledge regarding them and their role with the children
  - The role of grandparents and the significance of their role/impact including support, risk (intergenerational neglect) and vulnerability due to their ages.

- **Quality of doorstep welfare checks**

Key learnings about welfare checks versus police powers

  - Statutory powers not being exercised to their fullest extent, particularly around overriding consent to speak directly to children and ascertain their experience
  - Variation in terms of officers' descriptions and language used during doorstep visits with observations ranging from "children healthy" and “appeared well” to also stating at the time, “a smell resembling that of a dead body coming from the property”.
  - The lack of training for frontline officers around neglect to ensure statements such as “the children looked well” can be evidenced.

- **Medical Neglect**

Medical aspects of children’s presentations were accepted and not explored, i.e. soiling / wetting/ UTIs and regarded as consistent with their medical needs; there was a risk of diagnostic overshadowing rather than practitioners maintaining professional curiosity as to the possible cause(s) of their presentation.
Missed medical appointments, children not being brought to appointments, and dental neglect were present in a number of audits.

- **Educational Neglect**

There was evidence of schools working hard to support children, often stepping in for parental responsibilities such as daily collection, providing breakfast, and supplying clean clothes. Several audits identified poor school attendance as a concern, including the challenges with non-statutory age children and nursery absences, which delayed a possible early intervention of child neglect. It was noted there was often frustration by the lack of progress in cases where social care had not been able to access the home to fully understand the state of the living conditions which were suspected to be very poor and damaging to the children's health and development.

- **Approaches to neglect**

Challenges in addressing child neglect identified included:

- When cases lacked a clear incident to trigger extra support.
- Some audits noted drift and restarts.
- The importance of language with the need to distinguish between "disguised compliance" and "non-compliance".
- Inconsistency in the use of the neglect toolkit. This was used in all Kingston audits by social work partners and a school; however, it was not used in any Richmond audits at the time of moderation. Both national and local learning reviews on child neglect have stated the importance of understanding the child's lived experience, as well as the importance of measuring and evidencing change over time. This approach is essential for identifying cumulative or escalating risks. Increased use of the neglect toolkit across the multi-agency network would provide a valuable means of supporting the measurement of sustained changes over time.
- Differences in child protection medical thresholds highlighted the need for consistent criteria.

- **Judicial arena - Public Law Outline and Legal Threshold**

The length of time children living in neglectful care, pre-birth and repeat plans, revolving door, and the high threshold being applied to neglect cases.

- Similarities as seen with KRSCP Local learning review concerning neglect, in gathering sufficient evidence of neglect and transferring this into legal processes.

- **Cultural competence**

Generally, the audits captured limited information about children's identity, it was felt there could be more explicit consideration of families' Social GRAACES and examination of how this may impact on the multi-agency professional response.

6. Findings from the Scrutiny of the deep dive

The role of independent scrutiny is to provide assurance in judging the effectiveness of multi-agency arrangements to safeguard and promote the welfare of all children in a local area, including arrangements to identify and review serious child safeguarding cases. The following

information details the Independent Scrutineer's findings in considering the methodology adopted and findings of the deep dive audit activity, triangulated against the published policies, procedures and guidance and the views from the meetings with young people, practitioners and their managers.

The analysis has been undertaken using an adaptation of the 6 domains framework, adapted from a systems framework.[1]

National and wider Context

Child neglect is a major national concern with long time impact for the child. Across South West London the Joint Child Neglect Strategy is a positive development, developed with the purpose of unifying approaches, resources, and expertise to ensure that all children receive the care and protection they need to thrive. This strategy was developed by a Neglect Task and Finish group, which was convened in response to a number of rapid reviews where neglect was a significant feature. The neglect toolkit is currently under review as part of an action from this group. However, in meeting with practitioners where there was evidence of the toolkit being used this was positive in developing partnership with parents and providing evidence of progress or lack of progress.

Strategic Partnership Governance

The KRSCP priorities for 2024-2026 have been agreed and includes child neglect, with ongoing work within the business plan to support multi-agency work on this priority area. Given the recognition both locally and nationally of this area as a priority, the focus of this deep dive is

[1] Braye. S, Orr, D. Preston-Shoot, M. (2015) Serious case review findings on the challenges of self-neglect: indicators of good practice. *The Journal of Adult Protection*. 17(2):75-87.
Brandon, M. et al (2012) *New learning from serious case reviews: a two-year report for 2009-2011*. DFE. Research Report DFE-RR226.

highly relevant. It provided an opportunity to test out the findings and responses to the emerging themes from the number of reviews detailed in section 4 above where children were experiencing neglect.

In viewing the data contained within the training report there is a comprehensive programme of training delivered. To reflect our business priority on neglect, a focussed term of learning activity on this topic was delivered from September to December 2025. This included a variety of learning events and a conference. All of the events reflected the newly developed joint South West Neglect Strategy with the aim of embedding it across the partnership.

Learning from Child Safeguarding Practice Reviews (CSPRs) lunch time briefing sessions were delivered during the period 2024-25 to disseminate learning from both local and national CSPRs and rapid reviews to multi-agency practitioners. These sessions have seen a significant increase in attendance when compared to 2023-24.

KRSCP held a child neglect conference jointly with Wandsworth in November 2024.

A half-day learning event "Focusing on Child Neglect for Multi-Agency Practitioners" is planned and is due to take place imminently. At the time of writing this report in the region of 200 attendees were planning to participate. The learning event will launch the shared neglect strategy and the revised online toolkit.

The impact of this event will need to be evidenced as part of the ongoing work of the partnership.

Organisational support

In hearing the views of practitioners there was evidence of a range of support available to practitioners to support them in their work with children where there are indicators suggesting they may be experiencing neglect.

- There was good awareness and evidence of use of KRSCP policies by practitioners
- Practitioners felt supported from managers/safeguarding professionals
- Practitioners spoke about the availability and value of single agency and multi-agency training
- There are a wide range of approaches used to share learning from local and national reviews including 7-minute briefings, training events both face to face and online and the distribution of learning via all-staff emails

In addition, the development of the Think Space approach is an example of good practice. This offers the opportunity for practitioners to reflect upon their practice when working with children and their families in a safe environment.

Team around the child

Practitioners openly spoke about their positive experience of working together as agencies to support children at risk of neglect.

There was evidence of practitioners' knowledge of the neglect toolkit although as previously highlighted the use of this is not consistent.

Direct work with child and family

In the conversations held with the practitioners the commitment to direct work with child and families was evident. Although it can be seen from the themes identified in the deep dive children were not always seen by professionals. The audits submitted by Achieving for Children included the family's view. Examples of child focused practice included schools going above and beyond to support children.

Given the emerging theme of hoarding there is an opportunity to consider joint work with the SAB.

Voice of the child

- In reading the audit outcomes and in conversations with practitioners and managers, commitment to gaining insight into the lived experience of the child was evident
- There was evident in a number of audits, that the voice of children was sought and recorded
- The voice of children is a golden thread in KRSCP training events

At the meetings held with CYP the following key areas were explored:

- What life was like living in their home before social workers became involved?
- Who helped make changes for them and their family?
- What changes made a difference?
- Whether there anyone they talked to about their experience?
- If they could change two things about their experience, what would it be?
- What they wished more adults understood about their situation?

The key themes emerging from the views of then young person whose experience the Scrutineer was privileged to hear closely correlated to themes identified in the audit activity and included:

- The interface between adult health challenges and children experiencing neglect including the experience and impact of living with an adult where hoarding is present
- The significance of professionals being curious and the importance of seeing what lies behind the child's presentation – "My anger was internal anger about my mum's situation", "I was experiencing feelings of pain/anger/ different emotions"
- Identification and responding to the child's experience as a young carer
- The loss of childhood, a period children can never get back "Before being in care – I was a young carer for my mum and my brother, I was rushed into adulthood".
- Finding ways to hear the voice of children, recognising the issue of trust "I was always told not to trust professionals".
- Relationship building – avoiding changes of professionals resulting in "Telling my story repeatedly"
- The importance of a trusted individual including friends and their families "I spoke to my friend, she told the teacher, I was down, self-harming. "

Conclusion The deep dive process undertaken by KRSCP has been a robust approach in examining the effectiveness of current practice in protecting children who are living with neglect. The process has been open and transparent, identifying good practice and areas for further improvement.

In scrutinising the range of data and engaging within the deep dive a number of strengths are evident including the strength of multi-agency working, the value placed on KRSCP learning and development events and available policies and resources.

The deep dive resulted in a number of emerging themes. These themes aligned to themes identified by the Scrutineer from reading the range of documents outlined in section 4 above, conversations the scrutineer held with practitioners and managers and the conversations with children and young people. The moderation report developed by the partnership team will have been shared with Kingston and Richmond Safeguarding Children's Partnership's Safeguarding Executive Group and subgroup chairs with the plan to develop an action plan to address the learning themes.

It is clear that a lot has been done across the partnership to respond to neglect. It is recognised that the nature of neglect is complex, presenting challenges in evidencing sustained change with a need to ensure there is strong evidence of how the neglectful parenting is impacting the child.

The deep dive has shown some real strengths in partnership working and the child centred approach adopted by many practitioners. In considering the findings from KRSCP Multi-Agency Audit Child Neglect cases April 2020 there continues to be some repeated themes, which demonstrates there is more work to be done.

The themes emerging from this review will support the development of a plan, which in taking forward the actions offers an opportunity to improve the experience of children.

In undertaking the scrutiny of this priority area, the Scrutineer would ask the partnership to consider the following areas:

- Consideration to undertaking a focused piece of work to understand what the barriers are to achieving improved consistency in the use of the neglect toolkit
- In launching the recently developed joint South West London Child Neglect Strategy and revised toolkit consider what the measurement of impact will be
- In planning future deep dives consideration should be given to a 2-year cycle with year 1 undertaking the deep dive and year 2 focusing upon implementing the actions and assessment of improvement "what difference have we made?"
- Consideration should be given to what opportunities there may be for conference chairs and supervisors to ensure practitioners are evidencing neglect and change through the use of the toolkit
- Consideration should be given to what more can be done to raise public awareness of neglect and how they can take forward concerns
- Consideration to what opportunities there may be for any joint work with SABs around hoarding

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Date of report: August 2025

Appendix1 Terms of Reference

Neglect Deep Dive - Spring 2025

KRSCP Vision:

'Working Together to keep children's safety and wellbeing at the heart of everything we do'

Methodology:

A deep dive theme into neglect.

The KRSCP Quality and Innovation Subgroup proposes to audit 8 children's cases. This will comprise a sample of 4 Kingston and 4 Richmond children. Any adaptations to the KRSCP multi-agency audit tool specific to this deep dive will be considered and agreed upon.

Within this sample we would anticipate there to be a range of factors to explore and from discussions we are keen to include consideration of the following:

- The impact of long-term and persistent neglect on children and young people.
- Voice of the child and their experiences.
- The understanding of the child and family's race, culture, faith, religion and identity as a family system and the impact on parenting.
- How neglect is understood, identified and responded to by all agencies. *Consider normalisation and professional fatigue*.
- To understand the various forms of neglect such as educational neglect, medical neglect, physical neglect and affluent neglect.
- To understand the impact of repetitive cycles children may experience such as repeat referrals, repeat child protection plans and repeat child in need plans.
- The support tools/interventions professionals have used to engage with both parents/significant other caregivers.
- The use, understanding and application of chronologies and family history to inform decision making.

Information sharing and confidentiality:

Local Safeguarding Partners are responsible for ensuring that relevant information is shared in a timely and proportionate way, both within the local area and across local authority boundaries. Local Safeguarding Partnerships should promote the use of the "London Multi-Agency Safeguarding Data Sharing Agreement for Safeguarding and Promoting the Welfare of Children" London Multi agency Safeguarding Agreement for Safeguarding and promoting welfare of children pdf which sets out the legal basis for sharing information between agencies in London.

This Data Sharing Agreement enables authorities to share data on performance, quality assurance, learning and impact analysis.

In addition, KRSCP (the Lead), will complete a Data Protection Impact Assessment (DPIA).

The reason is that:

- Information for many data subjects will be shared with KRSCP the purpose of coordination of the chronology and the multi-agency case audit across the partners.
- KRSCP will also need to access information about the data subjects for the purpose of analysing the gathered information, however the report will be fully anonymised before being shared.

Participation:

- Practitioners will be involved in contributing to the audits with the auditor and attending two half-day multi-agency moderation sessions. Practitioners' views will also be sought by the independent scrutineer.
- Audits to be completed within each agency.
- Practitioner focus groups will be held with the facilitation of the Independent Scrutineer.
- Parents' views will be sought by the AfC auditor.
- Children and young people's views will also be sought by the independent scrutineer.
- Voice of the voluntary sector and charities.

The Independent Scrutineer will be asked to consider and report around neglect on a strategic level; for example, liaising with practitioners to consider:

- Is learning from local learning, and child safeguarding practice reviews, relating to neglect, being effectively disseminated and embedded?
- Does the KRSCP have appropriate policies and training in place to support partners' practice? Independent scrutineer to test with multi-agency frontline practitioners.
- Does the KRSCP have adequate intelligence to support partnership understanding and response to neglect?

Learning:

We would propose a learning event be held in September 2025, with some ideas for inclusion as follows:

- Feedback from independent scrutineer on strategic practice
- Reflection of key findings and learning from multi-agency audits
- Consideration of any internal reviews captured from partner agencies that can inform us about practice in this area
- Voice and experiences of children and their families.

Outline timeline:

The following timeline is indicative and subject to refinement:

7 January and 19 March	Scoping meeting and Audit tool to be agreed Children identified within the cohort- 8 children in total (LBR and 4 RBK)
24 March	Chronology template to be shared with agencies

4 April	Completed chronologies returned
28th April	Audit distribution to agencies
	Independent Scrutiny led work initiated and runs throughout the timeline of the deep dive process
26th May	Deadline for audit return
2nd June	Received Audit shared with all agencies ready for moderation sessions
Monday 9 June (1-5pm) and Friday 13 June (9-1pm)	Moderation sessions for audited cases
Monday 23rd June	Moderation key findings and learning meeting with moderation facilitators group
7 July	Draft moderated report shared and comments revived by 11 July
14 July	Moderation report shared with independent scrutineer
September 2025	Independent Scrutiny report draft reviewed and finalised
TBA	Independent Scrutiny report to be presented to the KRSCP
30 September	Multi-agency learning event