Executive Report

Local Authority Designated Officer (LADO)
Annual Report
2019/2020

Lead director: Caroline Tote

Useful information

■ Ward(s) affected: All

■ Report author: Jude Atkinson (LADO) and Lesley Booth (LADO Manager(

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The executive decision-making process

Stage	1 **"Policy development"** Private meeting	2 **"Defining our approach"** Private meeting	3 **"Giving notice"** Public	4 **"Announcing the decision"** Private/Public meeting
What happens	Initial briefing of City Mayor, Deputy or Assistant Mayor/s or Cabinet about new policy or decision that is needed	Officers draw up options paper for City Mayor etc.	We give 5 clear days' notice of our decision	We let you know what our decision is and seek final comments questions from press, public, other Councillors
Where you can find out more	Informal notes Briefing documents Forward Plan Scrutiny may start to help develop the idea	Agenda, report, minutes Forward Plan Scrutiny may start to define our approach	Agenda, report Forward Plan	Decision record Press release Forward Plan Scrutiny may start to ask for a "pause" of the decision or to make sure our decision works as we said it would.

"Key decisions" are defined as:

An executive decision which is likely: -

(a) to result in the Council incurring expenditure which is, or the making of savings which are significant having regard to the Council's budget for the service or function to which the decision relates; or

(b) to be significant in terms of its effects on communities living or working in an area comprising on or more Wards in the City.

Expenditure or savings will be regarded as being significant if: -

(a1) in the case of revenue the expenditure/savings are outside the approved revenue budget and are greater than £250,000

(a2) in the case of capital, the capital expenditure/ savings are £1,000,000 or more.

Not all decisions to be taken by the Cabinet will be key decisions.

PLEASE COMPLETE SECTIONS 1, 2 and 3 ON THE NEXT PAGE. IF YOU SUBMIT FURTHER INFORMATION, PLEASE USE CLEARLY MARKED APPENDICES

1. Decision Summary:

Members and the City Mayor to note the work and activities undertaken by Leicester City's Designated Officer.

The function of the Local Authority Designated Officer (LADO) is a key aspect of the overall safeguarding activity of the Local Authority and partner agencies. The purpose of the LADO is to enable and ensure agencies work together effectively to safeguard children from neglect and abuse by individuals employed in positions of trust (professionals and those in public office -employee, volunteer or student paid or unpaid).

Following presentation to the responsible Leicester City Council's Director for Children Services, Lead Member for Children, City Mayor and LSCBP the report will be placed on the LSCBP website, as a publicly accessible document.

2. Why it is needed:

The purposes of this report are:

- To provide an overview of the management of allegations against the children's workforce and the role of the LADO in Leicester City for the period 1 April 2019 to 31 March 2020;
- To provide opportunities for reflection and potentially influence/ inform future plans of actions and development of services across agencies;
- To identify themes and patterns leading to more robust training and information sharing

In addition, the annual LADO report is part of the wider LSCBP Annual report.

3. Options

3.1 To note the report and the actions identified or the year ahead.

4. Tell us how this issue has been externally scrutinised as well as internally?

4.1 LADO activities are being scrutinised as part of the OFSTED Inspection framework.

5. Financial, legal and other implications

5.1 Financial implications

There are no identified financial implications

5.2 Legal implications

There are no direct legal implications arising from the contents of this report. Pretty Patel, Head of Law- Social Care & Safeguarding Tel: 0116 454 1457

5.3 Other Implications (You will need to have considered other implications in preparing this report. Please indicate which ones apply?)

N/A

6. Background information and other papers:

7. Summary of appendices:

Appendix A -The LADO Annual Report 2019/2020

8. Is this a confidential report (If so, please indicated the reasons and state why it is not in the public interest to be dealt with publicly)?

No

9. Is this a “key decision”?

no

Appendix A

Local Authority Designated Officer (LADO)

Safeguarding and Quality Assurance Unit
Social Care and Early Help

Annual Report

1st April 2019 – 31st March 2020

Contents:

1. **Introduction**

2. **Overview of LADO activities. Performance data analysis**
   2.1 Total referral numbers
   2.2 Outcome of LADO contacts
   2.3 Contact by category
   2.4 Who are contacts about?
   2.5 Who makes contact with the LADO?
   2.6 Timeliness of the LADO investigations

3 The voice and experience of children

4 Partnership working and training

5 Quality assurance of LADO activity

6 Conclusion and Next steps

1. Introduction

The role of the LADO is set out in HM Government guidance Working Together to Safeguard Children (2018) Chapter 2 Paragraph 4 and is governed by the Authorities' duties under section 11 of the Children Act 2004. The Local Authority Designated Officer (LADO) is employed by Leicester City Council and its function is set out in Leicester City Children Safeguarding Partnership Inter-Agency Policy and Procedures.

The work of the LADO focusses on managing the process of investigation into allegations of harm made against adults who work in positions of trust with children and young people. The overall aim is to ensure all allegations however small are followed up thoroughly to ensure a safe and fair process for all involved.

The LADO annual report is aimed to provide an overview of the management of allegations against the children's workforce and the role of the LADO in Leicester City for the period 1 April 2019 to 31 March 2020. It also provides opportunities for reflection to a wide audience and potentially influence/ inform future plans of actions and development of services across agencies, to prevent children and young people being harmed by adults in positions of trust.

2. Overview of activities: performance data analysis

2.1 LADO contacts

In the period, the LADO Service has continued promoting its advice line to ensure appropriate levels of advice and guidance are available to employers and referring individuals. The table below reflects a breakdown of contacts received by the service in the past 4 years:

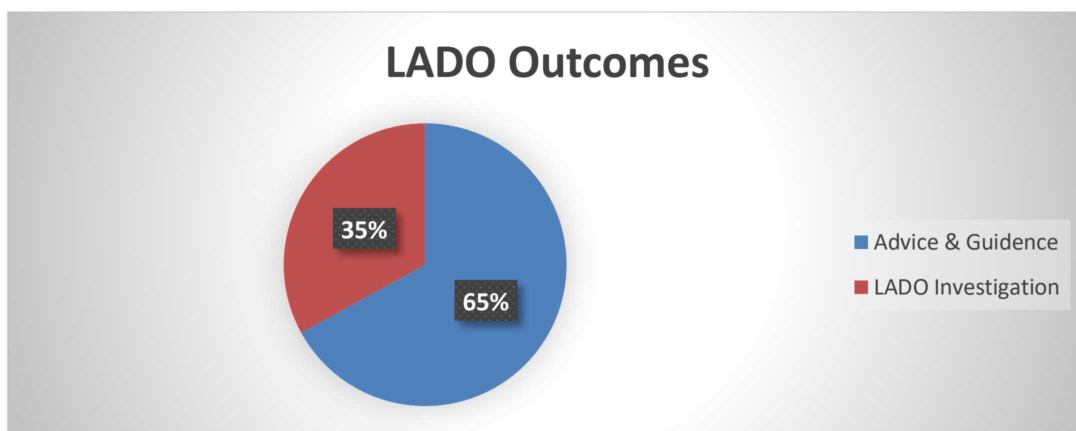
Period	Number of contacts
2016-2017	329
2017-2018	450
2018-2019	378
2019-2020	304

Over the last 4 years there has been a reasonably consistent number of contacts made with the service. The slight increase in 2017-18 was due to changes in staffing and moving to improved recording systems.

2.2 Outcome of LADO contacts

It is important to review the outcomes of LADO contacts in order to understand any potential themes/ training required across the workforce working with children. The LADO maintains a database of all allegations and concerns received allowing further targeted analysis and annual reporting.

Breakdown of the number LADO contacts, based on their outcomes is reflected on the chart below.



Our simplified, easily accessible duty system designed to enable a telephone discussion between the LADO representative and referrer has led to 67% of the contacts being concluded with **advice and guidance** to the employer. N.B The contacts did not meet threshold for harm / risk of harm- No further action after initial LADO consideration

	Number 2017/18	% of total	Number 2018/ 19	% of total	Number 2019/ 20	% of total
Number of contacts with the outcome of Advice & guidance to the employer/organisation.	255	57%	248	65.7%	204	67%

This 67% percentage reflects that employers and organisations are seeking safeguarding advice for their children and organisations. This is an opportunity for the LADO to share their knowledge and expertise about risk in organisations and from individuals, to assist employers to deal with individual issues and consider wider safeguarding activity.

The LADO advice and guidance response engages many different agencies and voluntary sector leaders and is used to promote safer working practices and cultures focussing on hearing children and promoting their safety in organisations.

33% of LADO contacts led to a **LADO investigation**. In these circumstances, the LADO facilitated multiagency information sharing in order to determine threshold and ensure employers have all relevant evidence for well-informed risks assessments and management.

The LADO service has close links with Police, safeguarding in education officers, adult safeguarding (PIPOT), independent foster home review officer and a range of external bodies that can support safeguarding activity if this is identified within the advice and guidance contact.

Below is a breakdown of the outcomes of LADO investigations:

Outcome of LADO investigation	100	35.5%
Unfounded (*there is sufficient evidence to disprove the allegation)*	33	11%
Unsubstantiated (*there is insufficient evidence to prove or disprove the allegation)*	22	7%
Substantiated (*there is sufficient evidence to prove the allegation balance of probability)*	38	12.5%
Malicious	0	0
Ongoing cases	7	2.5%

The outcomes above are based upon threshold of harm or risk of harm on balance of probability and in relation to the four categories of abuse: risk of neglect, sexual harm, physical harm and emotional harm.

- An unsubstantiated outcome is only used when after all enquiries the allegation cannot be proven or disproven. This outcome is used with caution as it can result in a less clear conclusion.
- All substantiated allegations of harm/risk of harm will be considered further to identify ongoing risk of harm to children and actions required to safeguard children in the longer term.

- For all substantiated allegations, consideration is given to referrals to regulatory bodies and The Disclosures and Barring Service (DBS). In the period 20 referrals have been recorded as warranting referrals to DBS.

It is positive that there are a much lower number of ongoing cases at this stage indicating that cases are progressed timely.

2.3 Contact by category

The category of harm is not dissimilar from previous years, with the contacts about physical harm to children being the highest percentage. The reason it is the highest is that this category includes restraints, mismanagement of behaviours, misinterpretation of adult's behaviour as well as direct physical harm. This has consistently been a theme over the reporting years

Type of contact	Number 2017/18	% of total	Number 2018 /19	% of total	Number 2019 /20	% of total
Neglect	90	20%	42	11%	47	15%
Sexual harm	104	23%	100	26.5%	72	24%
Physical harm	183	41%	191	50.5%	142	47%
Emotional harm	52	11%	45	12%	43	14%
Multiple	21	5%				
Total	**450**		**378**		**304**	

The table above shows that contacts about physical harm to children is the highest percentage. The reason it is the highest is that this category includes restraints, mismanagement of behaviours, misinterpretation of adult's behaviour as well as direct physical harm. This has consistently been a theme over the reporting years.

Sexual abuse is the next highest percentage. There continues to be a noticeable difference between the LADO contacts for sexual abuse and the percentage of children subject to child protection plans for 'risk of sexual abuse' (which is significantly the lowest percentage of all categories of child protection plans). The difference is considered to be due to an increase in the identification and questioning of: 'online' sexual harm of children, grooming type behaviours and sexual exploitation of children from adults who work with children. Additionally, historic allegations of harm are often of a sexual nature.

2.4 Who are contacts about?

The patterns of contacts remain like other years with some small variations in the percentages. The occasional 'spike' in contacts from organisations are noticeably evident following targeted training. This is a positive repercussion from awareness raising events.

	2017/2018	2018/2019	2019/2020
Total contacts	450	378	304
Foster carers	20%	18%	20%
Education (non-teaching)	6%	6%	6%
Education (TA)	9%	9%	7%

Education (teaching)	19%	23%	20%
Sport	3%	4.7%	2%
Social Workers	1%	1.3%	2%
Health	3%	2.6%	6%
Day care	5%	9.7%	7%
Transport	5%	6%	6%
Youth Worker	1%	0.5%	3%
Faith	8%	4.2%	3%
Residential Care	7%	10%	13%
Police	1%	0.7%	0
Probation	0%	0.2%	0
Volunteers	2%	1.8%	1%
Others	11%	1.8%	2%
Historical previously working with children			2%

- Contacts remain the highest from education settings which is not surprising as they have a large employer base.
- This is followed by contacts in relation to foster carers. The contacts in relation to foster carers has been evaluated and several underlying themes were identified and shared with the family placements to aid with the quality of foster carers' assessments and monitoring processes. This shows a positive use of learning and improving services from information gained from LADO processes.
- One of the continued priorities in the next year is to ensure additional awareness raising takes place across the voluntary sector. In addition, some targeted work needs to be undertaken in relation to unregulated and private sector placements as noticeably the residential workers contacts are higher from external providers.

Children more vulnerable to harm in organisations include Looked After Children (LAC) and children with disabilities. 30% of all contacts to the LADO this year have been regarding LAC children and 13% about children with disabilities. This evidences that the ongoing awareness raising and understanding of organisational cultures is vital to the safety of the most vulnerable children.

2.5 Who makes contact with the LADO?

It is important that we understand where contacts originate from and where we do not receive contacts from to help plan future awareness raising.

Contacts from	2019/2020	%
Total contacts	304	
Family member, public and anonymous	12	4%
Education	70	23%
Health (including EMAS)	4	1%
Local authority (not social care e.g. transport, EWO, HR)	12	4%

External social care providers (e.g. LA LADO's, private sector fostering and residential care)	47	15.5%
Local authority social care (internal social care services Leicester city)	108	35.5%
Voluntary sector	5	2%
Regulatory and legal services (e. g CAFCASS, OFSTED)	11	4%
Police	35	11

2.6 Timescales for conclusion of LADO contacts

We fully comprehend the levels of anxiety and distress caused by investigations to individuals involved and we aim to reach a conclusion in the shortest time possible. At times, investigations take longer due to the depth of the enquiries and heavy reliance on expert advice (i.e. Police investigation into possible online offences).

There is no prescribed statutory requirement around timelines of LADO outcomes, however as an authority we have set our own internal expectations for the LADO activities. Data below reflects that timeliness of throughput has not improved in the last 12 months.

Quality assurance and management oversight has considered the timeliness of throughput. This has concluded that increasingly investigations are more complex and protracted e.g. historic allegations of abuse and abuse of children via technology. The LADO service has also improved in the systematic tracking of cases after the outcome. This means the LADO role/episode often extends beyond the outcome of investigation to be able to assure wider safeguards are actioned. This impacts negatively on the timeliness of LADO episode closing but adds value to the ongoing safeguarding of all children and is deemed good practice.

	2018/2019	2019/2020
% closed in 4 weeks	71.5%	52%
% closed in 12 weeks	86%	80%

3. The voice and experience of children

The LADO service actively promotes hearing children and their experiences from the outset to enable safe decision making for current safeguarding and future safeguarding. Children's voices and views are essential across all LADO processes. We aim to fully understand the child's lived experiences to assess the potential impact on them and future risks of harm to other children and advocate that the people around the children do the same. To do this the LADO will question and promote curiosity about the views of children and the impact on children of the allegation or concern.

The additional vulnerability of our Looked After Children and children with disabilities is an area the LADO has a heightened awareness to and takes all opportunities to advocate on the behalf of these children being heard.

Feedback to children is routinely recommended within LADO processes so that children are helped to understand that their concerns and views have been heard and taken seriously to give them confidence to raise future worries. This applies irrespective of whether children's allegations are upheld or not. The use of words and pictures is recommended and letters to the children from the LADO.

We also help professionals think about how adults can acknowledge or apologise directly to children if their behaviour was wrong or unacceptable (in appropriate circumstances).

Briefing sessions have been completed with the IRO's, Independent chairs, fostering services and Looked after Children teams focusing on 'listening and hearing children'. These sessions considered the learning from a range of serious case reviews and complex enquiries to promote a culture of hearing children in placements/organisations and highlighting how organisational abuse can develop if not identified ad tackled with long lasting consequences for children.

4. Partnership working and training

The LADO has maintained and continued to develop positive links with colleagues within the Local Authority, other Local Authority LADO's and with other partner agencies. Ensuring good links with colleagues and partner agencies is essential to continued learning and reflection on how to make organisations safer for children. This has led to close liaison with many statutory and voluntary groups to promote the safeguarding agenda and assist in the development of safer organisations.

The LADO is an active member of the regional LADO group and attends the national annual LADO conference. These sessions prove valuable in benchmarking us against other local authorities as well as developing practice.

One of the LADO's core responsibilities is to provide training and awareness raising sessions to partner agencies and other service provisions who work/come in contact with children.

The training and briefing sessions held in 2019/20 included:

- One training session to the designated safeguarding leads (DSLs) and a presentation at the DSL forum.
- Three generic training sessions for employers from range of settings via LSCB.
- Two briefing sessions for social care staff.
- 3 briefing sessions on hearing children and organisational abuse to LAC managers, family placements team, IRO's and CP chairs, FIRO and Safeguarding in education.
- Briefing session to children's residential home team manager
- Bespoke safeguarding awareness raising with a faith organisation.
- Safeguarding in education also promote the LADO role in all whole school training and DSL training.

The training sessions focus on LADO processes, understanding threshold, hearing children's experiences and the impact on children and adults, learning from serious case reviews and developing safe and healthy organisational culture.

5. Quality Assurance of LADO activity

In January 2020, one of the quality assurance spotlights focused on the activities of the Local Authority's Designates Officer (LADO). The LADO work is often hidden from view but is vital for safeguarding children.

The purpose of the activity was to consider the LADO practice across all areas of interventions: from responses to the initial LADO contacts to review of ongoing LADO processes.

The QA has included dip sampling of LADO contacts, deep dive audits of LADO work and a small sample of LLR QA activity. The latter being a new group set up to share QA activity across Leicester, Leicestershire and Rutland. (LLR)

Strengths identified:

- Interim safeguarding arrangements are considered consistently and at an early stage for children and are managed fairly for adults. Suspension is used in a proportionate was following comprehensive consideration of the alternative options available to the employer.
- History of the adult of concern, child and organisation is consistently considered and informs decision making.
- Case recording is thorough and completed consistently.
- There is evidence of good links between LCC LADO and other LADOs in the region;
- There are really good examples of the LADO focusing on the children's experiences and promoting children's voices amongst professionals. This is essential in the LADO process as often the adult is in a position of being a respected adult and the child in a much more vulnerable situation.
- There is a consistently good start to each contact and referral. Contacts are clearly recorded and relate the rationale for LADO involvement to the LADO criteria (WT 2018). Contacts and next steps are completed timely and the next steps are clear. The LADO is involved with initial strategy discussions appropriately chaired by children's services managers unless additionally complex.
- There is evidence of proportionate and appropriate responses noted. (This has improved from earlier QA when referrals based upon emails and were not clear)
- The threshold for practice issues and complaints and internal investigations are clearly recorded and advice and guidance thorough and supportive, with fairness to adult and safe responses for children.
- There is evidence of good consideration of other children who may be at risk from the adult.
- Adults views are considered and taken into account.

- Noticeable liaison with regulatory organisations, OFSTED, DBS, NTA, and with professional groups that oversee standards commissioning, FIRO, sports associations, committees, governors and many other groups.
- Evidence of escalation has improved over the last 10 months with positive results and impact on practice.

Areas for improvement:

- There have been some delays in admin tasks being completed in a timely way (minutes, action plans and cases being tracked)
- Some delays in escalation that has all resulted in drift in some cases.
- Earlier consideration of other children linked to the alleged perpetrators (i.e ex-foster children). At times, the experiences of these children are considered later in process and would be better at an earlier stage to prevent delays.
- More detailed recommendations to agencies with clearer expectations around timescales, reporting etc .
- More consistent letters to children to explain the outcomes of enquiries.
- There has been drift with some cases open too long (some not many) and this has resulted in the focus being less robust and other agencies/services losing focus (N.B we specifically selected these cases as part of our audits sample)
- Consistent consideration of support to adult, duty of care. Noted to be sometimes missed off recommendations.
- Consistent cross referencing to child's record.

The feedback received from referrers in relation to the advice line is positive, with increased levels of confidence around the guidance provided by the LADO.

In addition, our internal quality assurance activities have found consistency of thresholds application at the point of initial contacts and clear rationale for the decisions made.

Quality assurance activity has shown that good quality advice is provided to employers in their safeguarding practices, timely decision making, safeguarding arrangements initiated and if required multi agency safeguarding responses made. All the above based on the views and experiences of children and balanced with fair process for adults.

6. Conclusions and next steps

In the period, we have continued to benefit from a stable and experienced LADO service resulting in an improved service**.** The LADO service has developed a good reputation across the partnership, reflected in the positive feedback received regarding the advice and guidance provide, the timely responses and streamlined LADO processes.

We continue working with a wide range of agencies to maintain our positive working relationships and a heightened awareness of the LADO role. Our work promotes a cycle of good practice in which the role of the LADO and managing allegations is one part of the cycle.

This holistic approach is designed to provide a safer workforce and safer organisations for children and make it harder for adults to harm children through their work. During this period the LADO has emphasised throughout all contacts the experiences of children and ensuring children are heard and their experiences thoroughly considered. This remains essential and at the heart of our work to help organisations be safe places for children to spend time within.

Next steps

- We will continue to review our training offer on regular basis to ensue it's fit for purpose, relevant and reflects the updated guidance new developments in the field. Targeted training will be provided to the voluntary sector including faith, sports contact centre, faith settings, voluntary groups, services to children with disabilities and the private sector.
- We will work to improve timescales to ensure cases are concluded in a timely way by use of performance reports and systematic supervision on all cases open over 12 weeks.
- We will robustly escalate any delays in cases at an early stage to avoid delays.
- We will work with LADO colleagues within LLR to further develop and embed an LLR QA group. Further QA activities to be arranged under the 'peer review' arrangements.

Lesley Booth
Service Manager
10.06.2020