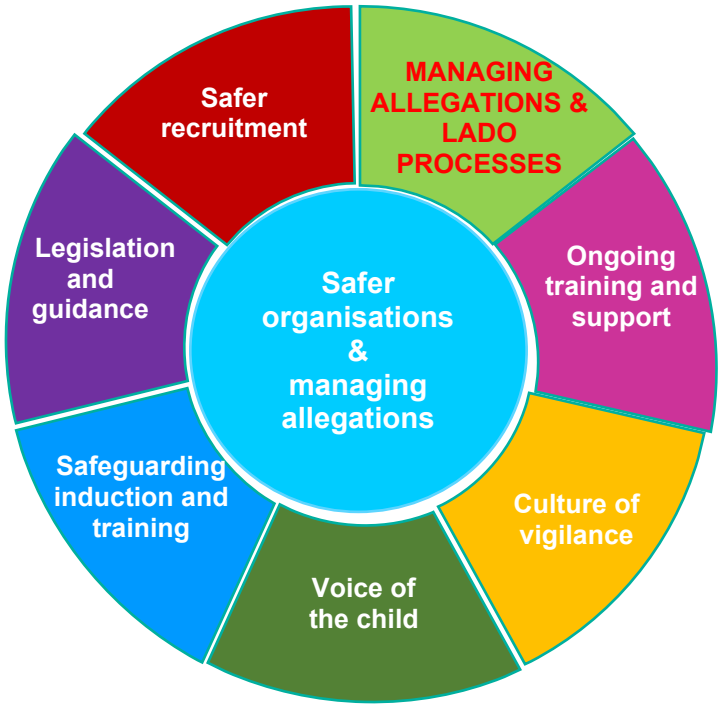
Leicester City Council

Safeguarding and Quality Assurance Unit
Children's Social Care and Community Safety
Social Care and Education Services

Local Authority Designated Officer (LADO)

Annual Report
1st April 2023 - 31st March 2024



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1. Introduction

The role of the Local Authority Designated Officer (LADO) is set out in HM Government guidance Working Together to Safeguard Children (2023) (WT) Chapter 4 Paragraph 223 and is governed by Local Authority duties under section 11 of the Children Act 2004. In addition, there is guidance about the role in Keeping Children Safe in Education (KCSIE).

The LADO function is further set out in Leicester City Children Safeguarding Partnership Inter-Agency Policy and Procedures. The LADO is employed by Leicester City Council and is supported by an experienced Independent Chairperson who specialises in LADO work, with total service hours meeting 1.8 full time equivalent.

The LADO manages the process of investigation into allegations of harm made against adults who work or volunteer in positions of trust with children and young people. The purpose of the role is to ensure all allegations of harm, whether seemingly minor or more significant are followed up efficiently to ensure a safe and fair process for children and adults involved.

The LADO operates according to the following "harm thresholds", i.e. Responds in situations where there are grounds to believe that adults working or volunteering in positions of trust have:

- 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 that they may pose a risk of harm to a child.
- Behaved or may have behaved in a way that indicates that they may be unsuitable to work with children.

This annual report provides an overview of LADO activity and management of allegations in Leicester City for the period 1st April 2023 to 31st March 2024.

It provides opportunities for reflection and may influence or inform future action plans and service development across partner agencies to promote the safety of children and young people.

2. Overview of LADO activity: performance data analysis

a. Number of LADO contacts

The LADO maintains data regarding all allegations and concerns received which allows for targeted analysis and annual and thematic reporting.

Over the last 12 months, the LADO service has continued to promote direct discussion with employers and referring individuals via a duty system comprising a telephone advice line and generic mailbox. The accessibility of the LADO advice line engages many different agencies and employers from both voluntary and statutory sectors, and enables exploration of concerns with employers, discussion about harm thresholds and safeguarding actions required, and the sharing of knowledge and expertise about risk in organisations and from individuals. In this way the LADO assists employers to respond to individual concerns as well as to consider wider safeguarding needs within their organisations.

From February 2024 the LADO service has promoted more widespread use of an existing referral form to support referring individuals and organisations in gaining advice and guidance in a timely way and to manage throughput effectively. Feedback on the use of the referral form has suggested that some streamlining of the form would be helpful to referrers and amendments are therefore planned.

It should be noted that the LADO service is available during office hours only and that outside of these hours referrers should contact the Local Authority social care services Children's Advice, Support and Prevention (CASP) team, or, if there are worries about immediate harm, with emergency services.

The table below shows the number of contacts to the LADO service in the past 5 years:

Period	Number of contacts
2019-2020	304
2020-2021	288
2021-2022	369
2022-2023	412
2023-2024	395

There has been a slight decrease in the number of contacts from 2022 - 2023 to the current year. This may be due to guidance introduced through KCSIE in 2021 about the management of "low level concerns" in schools having become fully embedded and more confidently applied, thus possibly resulting in less recourse to the LADO service by schools seeking advice and guidance, see section 2 d. below.

Contacts do remain at a somewhat higher level than has been seen in earlier years, except for 2020 - 2021 where there was a drop in contacts: this was felt to be an anomaly resulting from the reduction in face to face social and educational opportunities for children during the Covid pandemic.

High numbers of contacts overall reflect some of the complexities in understanding the incidence and management of child safeguarding concerns in organisations. It could be that concerns about harm to children in organisations are increasing or that children, parents, workers are more confident than they may have been in the past about sharing worries or concerns, or that employers are more ready to seek advice and guidance than may have been the case previously. It may be useful to consider gathering feedback around these specific themes to better understand whether or to what extent the above considerations are reflected in contact numbers.

Furthermore, the introduction in 2020 in KCSIE of a fourth harm threshold around "suitability" (subsequently aligned with WT) may have also resulted in further contacts to the LADO service. Anecdotally, it would seem that several referring agencies contact the service in order to seek reassurance and advice as to what might be deemed as conduct suggesting "unsuitability". Again, further interrogation of the available data could usefully satisfy or disprove this hypothesis.

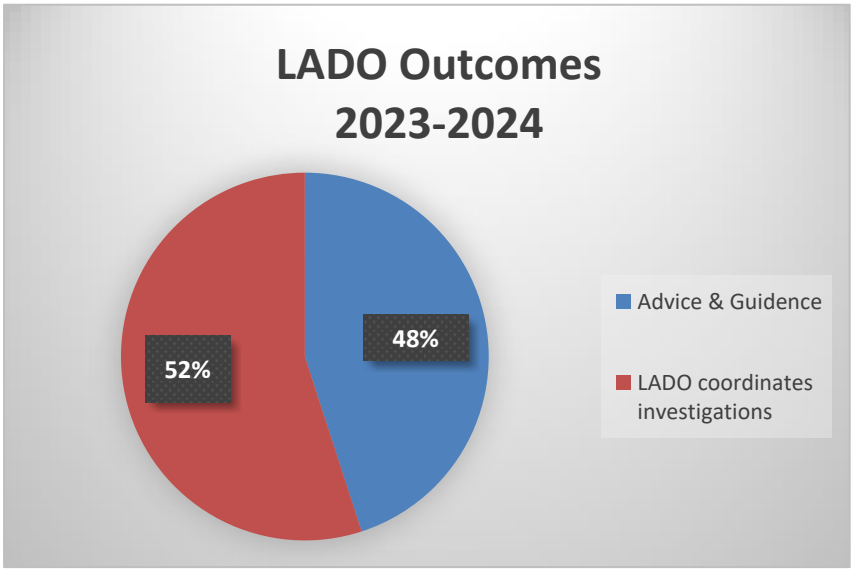
Our training events are available to a range of organisations locally and ensure the LADO role is understood these also prompt contacts to the service appropriately. See also **section 4. Partnership working and training** below.

b. Outcome of LADO contacts

There is no significant variation over the last year compared with previous years with regards the outcome of contacts to the LADO service. Review of outcomes helps us to:

- understand potential themes or patterns of concern.
- ensure that our service delivery is appropriate for the needs of our referrers.
- plan how we might best meet training and support needs across the children's workforce
- evidence consistency of response

A breakdown of the outcomes of LADO contacts for the year 2023 - 2024 is noted below:



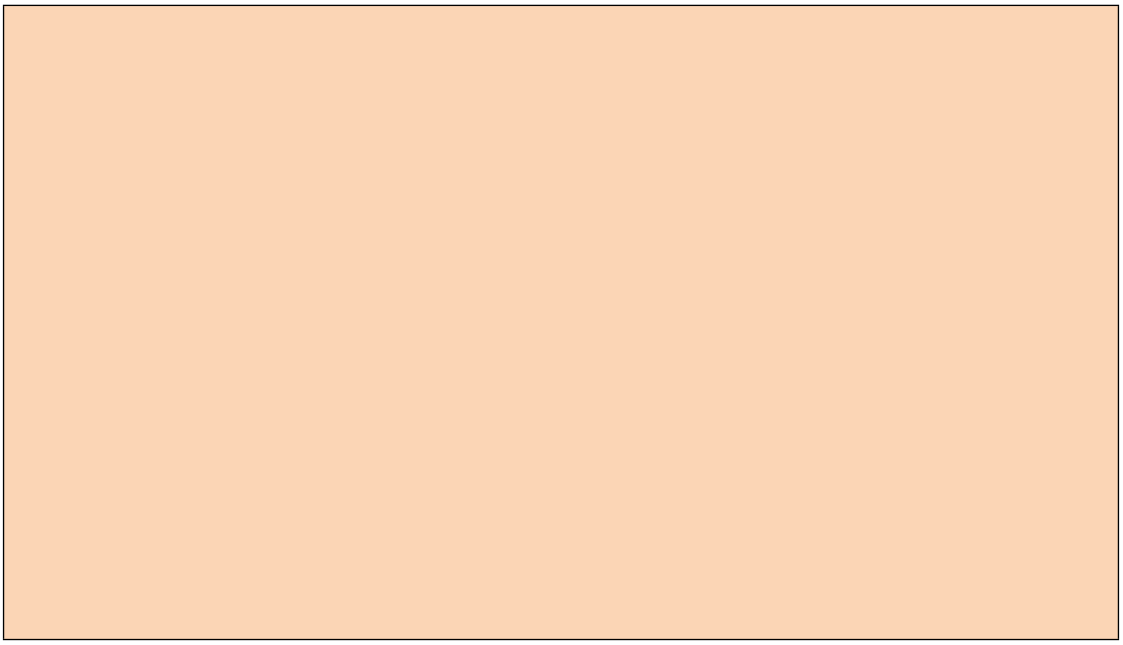
It is notable that **48%** of initial contacts this year have concluded with **advice and guidance** to the employer. Advice and guidance is offered in situations where concerns have not met the harm thresholds noted above and results in no further LADO action after initial consideration. Advice and guidance given can include advice about

- internal employer led investigations.
- managing practice or conduct concerns.
- organisational safeguarding.
- need to signpost to other agencies e.g. other Local Authority LADOs, adult safeguarding services among others.
- listening to and giving feedback to children and parents about concerns raised.

Advice and guidance may take the form of a "one off" discussion or could include several contacts over time.

Case example:
Advice and guidance

An employer contacted the LADO service to seek advice about the actions of a member of staff who had engaged in discussion with a young person about self-harming. The member of staff in an attempt to reassure the young person had shared some of their own experiences of self-harm with the young person and had also given the young person advice about strategies to use to reduce their self-harming.
The young person's parents were angry and upset about this. In discussion with the LADO service, it was concluded that harm thresholds were not met, there were no concerns about direct risk of harm from the member of staff to the young person or to other children and it was judged that this was a practice issue on the part of the staff member who had been well intentioned but had acted inappropriately.
Advice and guidance was given to the agency about reflection and learning for the staff member as well as exploration as to any need for support around their own experiences of self-harm. Advice and guidance was also given about feedback to parents with an emphasis on the importance of ensuring that the young person was adequately supported.



For comparison, a breakdown of the outcomes of LADO contacts for previous years is as follows:

	2019 - 2020	2020 - 2021	2021 - 2022	2022 - 2023	2023 - 2024
Number of contacts with the outcome of advice and guidance to employer/organisation	204 67%	185 64%	237 64%	218 53%	190 48%

These figures show that the number of contacts to the LADO service with the outcome of **advice and guidance** remained at a consistent level for the years 2019 through to 2022.

However what is also evident is that in 2022 - 2023 the number of contacts resulting in the outcome "advice and guidance" dropped by 11% , with a further drop in 2023 – 2024, i.e. over the last 24 months there has been an increase in LADO responses which go beyond advice and guidance, to the current position for 2023 - 2024 whereby 52% of initial contacts have led to the LADO coordinating further investigations.

A QA spotlight exercise took place in November 2022 sampling LADO contacts and concluded that there was a consistent response to contacts and that thresholds were being appropriately applied. A repeat exercise on this theme was undertaken in May 2024 alongside our LLR counterpart colleagues in Leicestershire and Rutland, with an audit involving "dip sampling" of a range of situations that had been referred through to our respective LADO services over the 6 months up to the end of April 2024. Spotlight questions focussed on threshold application i.e.

- What was the outcome of the contact?

- Was the decision on threshold influenced by child's voice?
- Did the contact require immediate interim safeguards?
- Did all 3 Local Authority LADO services agree on threshold?

The exercise concluded positively that there was consistency in threshold decision making across the 3 Local Authorities, with other learning for the 3 services identified e.g. around best approach to managing allegations in "managerless" organisations.

Quote from feedback activity 2024

Always clear guidance with a practical approach that considers 'real life' rather than textbook answers. Demonstrates excellent understanding of working in an education setting and the complexity of cases.
Really clear guidance and they were always available quickly to discuss any issues.
Lado support was understanding of the stress of the situation, the advice was clear and concise. The LADO was reassuring and supportive.

Where the LADO coordinates further investigation, practice is to facilitate multi-agency information sharing to further consider harm threshold and ensure employers have information sufficient to properly risk assess and safely manage their employees or volunteers. Paramount to this process is the safety of all children linked to the adult of concern, whether these links are through the adult's workplace, home life or in another employment or organisation.

Best practice is to begin by seeking an understanding of the experiences of the child or children involved and the impact to them of the alleged harm or concern. Wherever contacts that meet the threshold for statutory child protection processes are received, or where there is any element of doubt that this is the case, these contacts are always referred to police and social care services for consideration.

The need for employers to consider the support needs of employees and volunteers and to ensure they are well informed about LADO processes is also actively highlighted to employers at an early point during LADO involvement. To this end an information sheet has been developed for employers to share with their staff: this is routinely provided to employers.

To support the process of investigation, the LADO service works closely with colleagues within the Local Authority e.g. safeguarding in education officers, adult safeguarding services, and adult principal social worker, Looked After Children (LAC), Child in Need (CIN) and family placements teams, independent foster home reviewing officer, early education development team, human resources advisors. The LADO will also liaise as needed with colleagues from other agencies for example,

- Disclosure and Barring Service (DBS)
- OFSTED

- Regulatory bodies such as GMC, TRA, NMC
- Police
- Education services
- Compliance / safeguarding leads for bodies in sports, faith, voluntary organisations

Thinking about situations where the LADO has coordinated further investigation and the final outcomes subsequently reached, the below table gives details as to final outcomes over a 5-year period. These outcomes relate to neglect, sexual harm, physical harm, and emotional harm – see also **section 2.c Contacts by category** for further comment.

Final outcome of LADO process – based on balance of probability decision making	2019 - 2020	2020 - 2021	2021 - 2022	2022 - 2023	2023 - 2024
Percentage of total referrals – further investigations / actions beyond advice and guidance	35.5%	36%	36%	47%	52%
Unfounded *(there is no evidence or proper basis which supports the allegation being made)*	33%	25%	34%	39%	40% 86
Unsubstantiated (*this is not the same as a false allegation. It means that there is insufficient evidence to prove or disprove the allegation; the term therefore does not imply guilt or innocence)*	22%	20%	21%	31%	17% 35
Substantiated (*There is sufficient evidence to prove the allegation)*	38%	28%	33%	23%	26% 53
Malicious *(There is sufficient evidence to disprove the allegation and there has been a deliberate act to deceive).*	0%	1%	4%	1%	1% 2
False *(there is sufficient evidence to disprove the allegation)*	0%	4%	3%	0% 1	0% 1
Ongoing cases	7%	22%	5%	6%	12% 24

It is important to ensure that LADO processes conclude in a timely manner for all involved and as such it is positive that the number of ongoing cases open to the LADO service remains at a relatively low percentage.

However there has been an increase in ongoing open cases in the last year which is felt to be indicative of the complexity of situations and the impact this has on the timeliness of conclusions. Factors explaining this increase are the increasing complexities of some matters referred to the LADO, for example, where individuals have employments in more than one Local Authority area, where employer fact finding cannot be progressed in a timely way or where police investigations are protracted. This latter circumstance is often a feature of police investigations where there is a need for forensic examination of devices believed to contain indecent images or evidence of other sexual activity involving minors.

With regards the specific outcomes reached, it is positive to see that there has been a decrease this year in **unsubstantiated** outcomes. This outcome is reached when it is concluded that, after all enquiries have been completed, the allegation cannot be proven or disproven. The outcome "unsubstantiated" should be used only when there is judged to be nothing more that can be done to understand if an incident of concern is likely or not likely to have happened and harm caused. To conclude the LADO process with the outcome "unsubstantiated" can leave employers with an unclear understanding of any ongoing risk in the workplace and can also leave employees or volunteers under the impression that they have been vindicated which is not in fact the case.

A previous learning review reflected that further questions could have been posed to be clearer about an outcome. This has initiated ongoing reflection within the LADO service as to the use of the "unsubstantiated" outcome and the need to robustly question whether enquiries undertaken have been thorough enough to reach a clear outcome. The service remains very mindful that this outcome should always be reached with caution and that there is a need for professional curiosity as to whether other lines of enquiry can be pursued.

With regards to situations where allegations of harm are **substantiated,** these will always prompt further consideration by the LADO and LADO representatives as to whether there could be ongoing risk of harm posed by to children by the adults of concern and whether further action is needed to safeguard children in the longer term. For allegations with such outcomes, consideration is always given to the need for referrals to regulatory bodies and / or the DBS for barring decision. The LADO services continues to track with employers whether such referrals have been actioned and ensures with employers that wider safeguarding actions recommended through the LADO process have been completed and recorded. Actions might include involvement of our Local Authority Safeguarding in Education officers to advise and support organisations, encouragement to attend training events, approaches to governing bodies for sports and other groups, liaison with foster home reviewing officer and licensing teams e.g. taxi licensing. This practice reflects learning arising from local and national serious safeguarding incidents. In the period under review, several contacts have been recorded as ultimately warranting referrals to the DBS for barring decision.

On this theme, if an adult is dismissed or if they resign pre-empting a likely decision to dismiss them due to safeguarding concerns - a referral must be made to the DBS for barring decision. LADO service recording systems have recently added reference to this expectation to prompt confirmation with employers and give reassurance that this action is completed.

It is also positive to note that there has been no substantial increase in allegations of harm being recorded as **malicious.** Where allegations are made by children or their parents and are found to have no basis, agencies taking part in the LADO process will at times suggest that this is the most appropriate outcome, particularly if the children or parents involved have made previous, repeated unfounded allegations or there is concern about credibility. The LADO and LADO duty representatives are always mindful of the vulnerability of children and families who have reported experiences of harm, the difficulty of confidently attributing motives to those making allegations and the need to avoid stigmatising labels which might result in further vulnerabilities or disincentive to being believed. As such the outcome "malicious" is rightly applied only after careful consideration, and sparingly. It is noteworthy that managing allegations training events include discussion about adult perceptions of children's credibility and "truth and lies". See also **Section 3 The voice and experience of children** below and **Section 2 c contact by category** below.

Case example:
Substantiated allegation of harm

It came to light following concerns raised by family members that a counsellor employed in a local organisation had been making contact out hours and via personal phone numbers and emails with a vulnerable teenager accessing services at the organisation.

The content was of concern and seemed to imply that an inappropriate, possibly sexual relationship was developing for the counsellor and young person: there were indications of an exchange of gifts and unofficial meet ups. The counsellor seemed to be encouraging a very unhealthy dependence in the young person, at the same time discouraging the young person from accessing other support services.
Following a multi-agency strategy discussion, the counsellor was suspended, and a police investigation commenced: it was concluded subsequently that there was no evidence of sexual grooming on the part of the counsellor although the communication was clearly inappropriate. The counsellor was offered support from their employer and the young person was offered support by social care services. The young person was reluctant to share information about their interactions with the counsellor, but it was felt that the actions of the counsellor, and the loss of the counsellor as a support in their life, had a negative impact on them.
A series of multi-agency LADO meetings took place where safeguarding and support arrangements were considered, and conclusion eventually reached that the allegation that the counsellor had harmed a child were substantiated and their suitability to work in a position of trust called into question. The counsellor was dismissed from their role and a DBS barring referral made by employers. The counsellor was affiliated to a professional body who were kept informed

throughout the process of the concerns raised and who subsequently took action against the counsellor with respect to their private practice.

The LADO service continues to explore any themes or patterns of concern about organisations and their safeguarding cultures. This has been particularly notable over the last year set against complexities about the availability of placements for children which are matched to their needs and the quality of unregulated placements. There has also been a specific review of all allegations of harm within a particular residential setting.

Case example:
Organisational learning

Within the space of a few weeks, a series of concerns were brought to the attention of the LADO regarding physical interventions involving vulnerable young people in a health setting. There were difficulties for the LADO service in gaining information about what had taken place for the young people and concerns about recording and reporting of incidents and information gathering about the identity of staff involved. There had been previous concerns about similar in the past and pattern of concern addressed with the organisation: the renewed concerns indicated that there had been limited change in the organisation with regards safeguarding cultures and staff attitude towards young people and the use of physical interventions. Representation was made by the LADO service to senior managers within the organisation, contributing to a commitment on the part of the organisation to undertake a formal practice learning review.

c. Contact by category

Type of contact	2019 - 2020	2020 - 2021	2021 - 2022	2022 - 2023	2023 - 2024
Total referrals	**304**	**288**	**369**	**412**	**395**
Neglect	47 15%	67 24%	54 15%	58 14%	41 10%
Sexual harm	72 24%	79 27%	104 28%	104 25.5%	89 22.5%
Physical harm	142 47%	104 36%	164 44%	196 47.5%	207 52%
Emotional harm	43 14%	38 13%	47 18%	54 13%	58 15%

Breakdown of contacts by type of harm shows similar picture from previous years, with the contacts about risk of **physical harm** to children representing the highest number of referrals.

This category includes contacts relating to deliberate physical harm, physical interventions or restraints, mismanagement of behaviours e.g. in educational or residential care settings, situations where adult behaviour has been misinterpreted (adults may have felt they were guiding a child whereas a child may perceive that they were deliberately "pushed", "grabbed" or "shoved").

The LADO service remain mindful in communication with employers to highlight that some children's perceptions might well be influenced by previous personal history whereby they may now experience even innocuous or well-meant touch as invasive, threatening or "triggering". These discussions have been very helpful when talking with employers who might initially consider that a child is "over playing" an incident.

Sexual harm remains the next most frequent category of harm. Concerns relating to inappropriate social media contacts between adults and children continue to feature widely in referrals of this nature. Concerns about grooming behaviours and involvement in accessing indecent images of children are also examples of the harm to children considered.

Not infrequently concerns about sexual harm relate to the partners or adult children of employees or volunteers working in positions of trust. Employers confronted with these situations are often concerned about implications for children in the workplace, and understanding whether there is a transferable risk from their employee's home situation and managing risk assessments. The LADO service supports employers to consider the implications for safeguarding in the workplace and managing risk assessments to promote safety in the workplace for children.

d. Who are contacts about?

	2019 - 2020	2020 - 2021	2021 - 2022	2022 - 2023	2023 - 2024
Total contacts	304	288	369	412	395
Day care (early years settings)	7%	5.5%	4%	21 5%	16 4%
Education (non-teaching staff)	6%	4%	4%	16 4%	23 6%
Education (teaching support staff eg learning mentors)	7%	7%	8%	27 6%	28 7%

Education (qualified teachers)	20%	13%	18%	89 22%	68 17%
Faith	3%	3%	2%	11 3%	7 2%
Foster carers	20%	25%	20 %	67 16% *see breakdown below	55 14% *see breakdown below
Health	6%	8%	10%	32 8%	31 8%
Police	0%	0.5%	0.5%	1 0%	2
Probation	0%	0%	0%	0 0%	0 0%
Residential Care	13%	19%	18%	69 17% ** see breakdown below	88 22% ** see breakdown below
Social Work	2%	2.5%	2%	7 2%	3 1%
Sport	2%	3.5%	2%	12 3%	11 3%
Transport	6%	6%	8%	33 8%	23 6%
Volunteers	1%	1%	2%	9 2%	7 2%
Youth Work	3%	2%	0.5%	12 3%	1 0%
Other (eg security guards, driving instructors)	2%	0%	1%	6 1%	32 8%

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Foster carers:

In 2023 - 24, there were 55 contacts relating to foster carers as follows.
6 contacts about kinship carers – 11% (a drop from last year's 21%)
25 contacts about IFA foster carers - 45% (like last year's 42%)
24 contacts about Local Authority foster carers - 44% (a slight drop from last year's 37%)

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Residential settings

In 2023 - 2024 there were 88 contacts relating to residential care settings as follows
73 contacts about externally commissioned placements - 83% (an increase from last year's 70%)

15 contacts about Local Authority residential settings - LA residential care - 17% (a decrease from last year's 30%)

Overall patterns of contact remain similar to previous years with some variation.

The highest numbers of contacts and referrals continue to relate to **educational settings**, unsurprisingly so given that education services support a large employee base and daily contacts with large numbers of children across the city. The LADO regularly contributes to safeguarding training facilitated by safeguarding in education colleagues specifically for DSLs and senior school leaders. This supports the development of positive relationships and opportunities for constructive dialogue between the LADO service and education settings.

Contacts in relation to **foster carers** and workers in **residential settings** represent the next highest number of contacts.
36% of all contacts to the LADO service this year relate to individuals involved in the care and support of Looked After Children, although this is slightly lower than last year by 3%. While Local Authority foster carer and residential home referrals have again reduced slightly this year, contacts about foster care placements and residential care placements that are **non-Local Authority i.e. externally commissioned** have both risen. This indicates the potential vulnerability of children placed in external provisions which are often out of Leicester with reduced access for children to their social workers, families, and natural support networks.

It should be noted that the LADO service takes case responsibility for managing allegations where employee workplaces are City located. This includes IFA placements, non-Local Authority children's homes and taxi companies. The children using these services may not be Leicester City Looked After Children and may have other "home" Local Authorities. Conversely, Leicester City Looked After Children may be placed in or use services in other Local Authorities and it is the responsibility of the LADO in those Local Authorities to manage any allegations about services in their locality. However, the LADO service continues to systematically record information and will offer social workers advice and support in respect of allegations involving Leicester City Looked After Children are placed in other Local Authority areas: see also **section 6. Quality Assurance (QA) of LADO Activity** below.

It is encouraging that Looked After Children are being heard and their allegations taken seriously and reported to the LADO for consideration. Additionally, however as corporate parents for Leicester City Looked After Children, we want them to be safely cared for and reductions in contacts and allegations may be an indicator of increased safety. There has been an increase in recent years in smaller, private residential homes alongside a reduction in the number of foster placements and it is hoped that requirements for previously unregulated children's home around registration with OFSTED may result in a reduction of concerns about the care afforded to children in these settings.

It should be noted that Looked After Children may also be involved in allegations processes outside of their placements i.e. in their schools or extra-curricular settings.
Research and learning from case reviews around the UK tell us that **Looked After Children (LAC) and children with disabilities** are more vulnerable to harm in organisations.

7.3% of all contacts in 2023 - 2024 relate to workers caring for disabled children: this reflects a significant decrease from last year. Research shows that children with disabilities are "less visible" and "more vulnerable". Whilst an increase in figures may suggest more harm to children with disabilities, it could also indicate there is more vigilance and awareness of the harm that might otherwise have been unrecognised for these children.

The drop in contacts for children with disabilities is surprising as there has been a focus on children with disabilities over the last few years and the vulnerabilities for them when cared for away from home. This reflection will be considered, and consideration given to targeted training.

e. Who makes contact with the LADO service?

	2019 - 2020	2020 - 2021	2021 - 2022	2022 - 2023	2023 - 2024
Total contacts	304	288	369	412	395
Family members / members of the public / anonymous referrers	12 4%	9 3%	8 2%	7 2%	10 2%
Education services	70 23%	34 12%	74 20%	110 27%	94 24%
Health services (including EMAS)	4 1%	3 1%	25 7%	18 4%	18 4%
Local authority (not social care services – eg transport, education welfare, human resources)	12 4%	10 3.5%	8 2%	5 1%	11 3%
External social care providers (eg other Local Authorities, LADOs, private sector, IFAs, private residential care placements)	47 15.5%	28 10%	42 11%	28 7%	28 7%
Local authority social care (Leicester City)	108 35.5%	119 41%	145 40%	158 38%	121 31%
Regulatory and legal services, voluntary sector (eg CAFCASS, OFSTED, NSPCC)	11 4%	50 17.5%	37 10%	47 11%	70 18%
Police	35 11%	35 12%	30 8%	39 9%	44 11%

There do not appear to be any significant changes in who contacts the LADO service. Most agencies have a consistent pattern of contacting the LADO. This year's figures do show an increase in contacts from regulatory services and other bodies such as OFSTED, NSPCC, CAFCASS.

It is helpful to understand where contacts to the LADO service originate and equally to be clear about what agencies and organisations, or types of agencies and organisations, do not contact or seek support from the service. This enables the planning of awareness raising and training with relevant agencies. As in previous years, occasional 'spikes' in contacts from partner agencies and employers can be more noticeable following training events. There are regular training opportunities for partner agencies and employers with encouragement given on an individual basis and personalised invitations to agencies "new" to a relationship with the LADO service around attending training events, see also **section 4. Partnership working and training**.

The LADO service works hard to establish and maintain constructive working relationships with referrers and those who contact the service and is very proud to receive regular positive feedback and expressions of thanks for advice, guidance, direction, and support offered by the service.

f. Timeliness of LADO processes

	2019 - 2020	2020 - 2021	2021 - 2022	2022 - 2023	2023 - 2024
% cases closed in 4 weeks	52%	70%	67%	68%	64%
% cases closed in 12 weeks	80%	91%	92%	95%	89%

It is pleasing that despite the high number of contacts to the service this year that throughput to conclusion of LADO processes remains consistent. The data reflects a similarity in timeliness in the last 12 months to previous years except for 2020 – 2021 where figures again are somewhat anomalous as the reduced number of referrals due to restrictions on social contact enabled swifter throughput.

Quality assurance processes and management oversight routinely explore the timeliness of throughput.

There are no statutory timescales around the completion of LADO processes - but there are local expectations aiming to limit anxiety and stress caused by the process of investigation to all individuals involved, children, adults, and employers alike, as well as the need to reach defensible and safe positions for employing organisations.

At times LADO processes can be protracted where there are complex enquiries or a need to rely on expert advice e.g., where there is parallel police investigations relating to historical abuse or online abuse involving forensic examination of devices.

The LADO service continues to track appropriate cases after a final outcome has been reached to ensure that key ongoing safeguarding tasks are actioned. There has been a focus

on the importance of this tracking to reflect OFSTED advice at inspection in 2021 regarding the need to ensure recommended follow up actions are progressed. The LADO service utilises systems to track those actions to their completion e.g. employer referrals to the DBS for barring decision, referrals to regulatory bodies some outcomes of internal investigations if there is a potential need for further safeguarding advice and outcomes of criminal cases if further advice and guidance or action is likely to be required. This can extend the length of LADO involvement but adds value in terms of the wider safeguarding context.

During the cyber-attack experienced by Leicester City Council in March 2024 our service was able to continue with some disruption mainly to admin processes. There has been some impact on the ability to complete administrative tasks necessary to the conclusion of cases.

3. The voice and experience of children

Children's voices and views are integral to all LADO processes: the service recognises how important it is to understand as fully as possible the experience of children when assessing the potential impact of harmful or inappropriate behaviour towards them by adults in positions of trust.

Over the last 12 months good practice has continued to be promoted with respect to the voice of the child and the use of the Lundy Model of participation within LADO process.

The Lundy Model is considered in all LADO meetings to ensure that the child's voice and experience is fully understood when considering risk from an adult. The focus and value given to the child's participation and voice assists all involved to arrive at a conclusion and plan wider and ongoing safeguarding actions.

Records and forms have been amended to highlight children's voices and experiences.

Section 2 b. Outcome of LADO contacts above comments on views about "malicious" allegations and children telling "untruths". As noted, managing allegations training events include discussion about adult perceptions of children's credibility, the significance of "retractions" and "truth and lies". A briefing paper and assessment aid about "understanding retractions" has been prepared by the LADO service and is provided for consideration in cases where children may appear to "retract" what they may first have said, with areas to consider in these circumstances.

The importance of accurate chronologies is emphasised where suggestion might be made that a child has "made previous false or unfounded allegations" to evidence such assertions. The importance of securing an independent view of children's experiences is also emphasised e.g. in situations where Looked After Children in a residential home might not have been given opportunity to talk to their social worker about concerns, they may have about their residential workers.

The LADO service continues to promote the need to hear and take seriously the views of family members or others who raise concerns on children's behalf. Case learning following serious safeguarding incidents both within and beyond the Local Authority have shown the value of seeking out and hearing what family members have to say about the experiences of

Looked After Children in their care placements. In advice and guidance to managers where internal enquiries and / or investigations are being progressed it is recommended that enquiries routinely include the voice of the child and their parents or carers.

The LADO service benefitted from a presentation from a manager working in residential services at a provision for disabled children about communication. In June 2023 the LADO service also completed a quality assurance audit with respect to how the voices of disabled children are heard. This has led to reflection and learning as to our commitment to and success in securing the voices and views of disabled children in allegations processes and has resulted in some practice improvements e.g. challenge to partner agencies who may suggest that there are communication needs which limit the extent to which children's experiences can be heard.

A meeting last year with a group of young people, "The Co-Producers", alongside workers from the Participation and Engagement Service, has resulted in work taking place to develop a podcast explaining the LADO role which will be accessible to Looked After Children. This is an exciting project for the service, commencing in June this year.

Continued expectations of ourselves and our service are to:

- Actively promote listening to and hearing children and their experiences to enable safe decision making this includes listening to others who raise concerns on their behalf.
- Be questioning and curious about the views of children and the impact on them of allegations or concerns.
- Challenge "blameful" language and attitudes such as scepticism towards or disbelief of children
- Recognise the vulnerability of children in society overall and consider the impact of factors such as age, gender, sexuality, race, culture and heritage, religion, past experiences, and in particular past harms.
- Take account of the additional vulnerability of Looked After Children and children with disabilities and take all opportunities to advocate on behalf of these children.
- Promote the use of the Lundy Model to aid quality participation of children and young people.
- Routinely promote or in some cases give direct feedback to children and young people about the outcome of LADO processes which concern them e.g. through appropriately worded and presented letters or recommendation to those working with them.
- Continue to recommend safety planning work with children to ensure that they have courage and confidence to speak out if they experience further concerns or worries about adults in the future.
- Consider with involved professionals if there is scope for adults to acknowledge or apologise directly to children if their behaviour was wrong or unacceptable.

Case example:
Hearing the voice of the child

A concern was raised by a visitor to a school that they had seen Child S being physically mishandled by a teaching assistant TAB. TAB denied any wrongdoing, claiming that they were trying to defend themselves from being assaulted by Child S. It emerged that there were many concerns about TAB's overall conduct in the school: for example, TAB held a particular view of Child S and their needs which were not shared by leaders in the school. TAB spent a lot of time with Child S to the exclusion of other staff and was also influential with Child S's parents. Thus, TAB was felt to hold a lot of sway over Child S. Child S had little verbal communication and it was initially felt that it would be very difficult to gain their views about TAB.

However, over a period of weeks, observations of Child S and feedback from parents as to occasional comments they had made expressing anxiety about TAB, this was particularly in relation to returning to school after the holidays, this enabled a good understanding of Child S's voice and experiences around TAB which were fed into the LADO process and considered when determining actions to be taken with respect to TAB.

4. Partnership working and training.

It is crucial that the LADO service maintains **positive working relationships** with colleagues within the Local Authority, with partner agencies, statutory and voluntary groups and with other Local Authority LADOs, particularly those in neighbouring Leicestershire and Rutland. This supports effective responses around individual allegations concerns and assists work to promote safer organisations.

The LADO service continue to have positive working relationships with

- social care services within Leicester City (e.g. LAC, CIN, CASP, family placements team and placement commissioning teams and foster home independent reviewing officer, adult safeguarding teams, and adult principal social worker)
- other services within Leicester City Council (e.g. human resources, and early education development team)
- social care services in neighbouring authorities
- Leicestershire police (the Child Abuse Investigation Unit) a key contact has been identified within the police who the LADO is to meet quarterly and can contact for advice and "troubleshooting".
- health services (UHL and LPT)
- education services
- faith groups (e.g. Church of England Diocesan Safeguarding Advisor and Federation of Muslim Organisations)
- non-Local Authority placement providers

Special mention should be made of **Safeguarding in education** (SIE) colleagues who work closely with the LADO service. The SIE team consult regularly with the LADO service, promote the LADO role in their training events and have been made available to provide training and safeguarding learning to other small independent organisations where the safeguarding culture has been felt to be of concern after a LADO contact. While their services are not wholly designed for use in 'out of school settings' they have successfully engaged these settings to improve safeguarding. This is a strength of working closely together for the benefit of Leicester Children in out of school settings.

The LADO also has strong links with the **regional LADO group** which meets quarterly online and provides a forum for reflection, learning and good practice discussion as well as benefitting good cross authority working in complex cases. The LADO service also attends the annual LADO conference and has access to National LADO Network resources and participates in National LADO Network consultations.

The LADO service has a positive working relationship with the DBS regional outreach worker who is a good source of advice and support.

Quality assurance work in partnership with the LADO services in Leicestershire and Rutland has continued over the last year: this is reported on in **section 6. Quality Assurance (QA) of LADO Activity** below.

One of the LADO's core responsibilities is to provide **training** to partner agencies and other service providers. Training and briefing sessions held in 2023 – 2024 included:

- Termly "Safer organisations and managing allegations" training for DSLs and school senior leaders alongside Safeguarding in Education colleagues.
- Question and Answer and a Meet and Greet for foster carers "coffee and chat" meeting.
- Early Years forum presentation
- Termly "managing allegations" training for employers across the city is arranged in conjunction with LSCPB.
- Bespoke online presentation and learning event to the Association of School and College Leaders (ASCL)
- Bespoke presentation to residential services on the Independent Inquiry into Child Sexual Abuse and managing Allegations.
- 2 foster carer training sessions / workshops on the role of the LADO
- Termly presentation to ASYEs and other social workers on the role of the LADO
- Presentation to police
- A cross service-learning review was led by the LADO service following a complex investigation into allegations in residential setting. This resulted in a 7-minute briefing.
- Work with commissioning services on improving the quality assurance of placements following a learning review.

All training with the exception of the standalone presentation to ASCL takes place face to face and this has felt beneficial for the development of good working relationships.

All training sessions have a focus on safe and healthy organisational cultures, explain LADO processes and harm thresholds and consider the importance of hearing children's experiences and understanding the impact on children and adults. There is also consideration of learning from serious case reviews.

Feedback and comments on training

A massive thank you for the work and time … put into delivering the training session… The session was really well received, and colleagues have also asked to pass on their thanks… the session worked well and was really detailed and clear in setting out information that was incredibly relevant. It was an absolute pleasure collaborating with the service. We are hugely grateful to you for your time yesterday - **education colleagues.**

An excellent training course **– foster carer**

The training was the perfect amount of time, enough time was given for group discussion as well as being able to ask any questions or queries that you might have had, overall would recommend – **early years colleague.**

Amazing training, great delivery – **voluntary sector colleague**

5. Feedback from agencies regarding the quality of LADO input.

Feedback from agencies who use the LADO service is beneficial each year to inform ongoing improvements. Feedback foms were widely distributed to partner agencies during May 2024 with the aim of gathering feedback about the quality of the input from the LADO service. We were pleased to have received **37 responses.**

Questions asked:

The timeliness of response

- 93% of respondents said they received a timely response.

View as to whether the LADO response supported the safety of a child/ children within a setting/ organisation/workplace .

- 95% of respondents considered that the LADO response supported the safety of a child/ children within a setting/ organisation/workplace.

Views as to the quality of the input from the LADO service.

81% rated the quality of input as **Very Good.**

16% rated the quality of input as **Good.**

3% rated the quality of input as **Average.**

Feedback and comments about the quality of LADO input
As always, I received fantastic support from LADO service
Very knowledgeable and empathetic
Really clear guidance and they were always available quickly to discuss any issues
The professional that I spoke to was very informative, kind and put time and affect in for both the young person and staff member

Comments on possible improvements to LADO input/intervention to enable safety for children and fairness for adults.
When I have asked the LADO for support with external people/organisations who might pose a risk to students, I feel that there sometimes seems a reluctance to get involved. On occasions I have not been given feedback in these situations
The new online referral form is very long. Could less information be submitted as an initial triage maybe? Occasional lag in speaking to them - they seem very busy.
Response was timely but higher staffing levels so that there is a person available to speak to immediately if needed.

During this last year we gained feedback via an Ombusdman finding in relation to the LADO service.

We are generally very proud of our responsiveness to any referrals. In this situation we did not provide an update to a parent who directly approached LADO about her worries in relation to a teaching assisstant. We wholly accepted and apologised for not feeding back to the parent, we acknowledged that we should have done. This also initiated reflection on whether we record every time we are asked for advice and the LADO threshold is not met. We have updated our standards to refect this learning.

6. Quality Assurance (QA) of LADO activity

We recognise the LADO practice is a niche expertise that is limited within Local Authorities. Therefore, since 2019, we have worked with colleagues from Leicestershire and Rutland to progress and embed QA activities for LADO work across LLR. The strength of the QA forum is to reflect with colleagues on thresholds, outcomes, and safety within organisations. The QA is limited to an overview rather a 'deep dive' audit due to access to different LA systems. The forum is also used for considering themes emerging.

In 2022-23 we considered the initial learning and findings from the complex abuse investigation into the harm to children with complex health needs and disabilities within the Hesley residential childcare group in Doncaster.

We have revisited some of the themes this identified across LLR and reported to LSCPB our findings. We have completed two reports to the LSCPB on LLR audit work of the LADO role in the last year.

- LLR spotlight audit. Children with disabilities referred to LADO services within the three local authorities.
  and
- LLR LADO spotlight audit. LADO Threshold Application Leicester, Leicestershire, and Rutland.

The QA supported better cross boundary working, consistent application of thresholds, reflection, and good sharing of information on gaining the child's voice and promoting the systematic focus on whole organisation harm.

In January 2024 a spotlight QA activity was completed as there has appeared an increase in workload within the LADO service and it was necessary to consider if appropriate and proportionate responses have been applied that is consistent with Woking Together, Keeping Children Safe in Education and local safeguarding procedures. This was a Leicester City QA audit.

The spotlight activity dip sampled contacts to the LADO service over 3 months. During this time 95 contacts were made to the LADO service. Of the 95 the spotlight activity dip sampled 37 cases.

The focus was to consider threshold for LADO involvement, timely responses, robustness of advice and guidance, if interim safeguarding arrangements were being considered at an early stage and if the child's voice was evident in the process and informed the planning and actions.

We were pleased to see; timeliness of LADO responses and coordination of a wide range of involved professionals, that thresholds were appropriately applied, children's voices heard and acted upon, consistent consideration of interim safeguarding measures at the outset and advice and guidance in the main is shown to be of a good quality.

We noted we needed to improve on consistently providing a written summary of what was referred, what actions taken place, threshold application/outcome and rationale for this, recommendations and always considering how the child should be feedback to and evidencing consistently the child's voice.

7. Next steps for 2024 - 2025

During the last 18 months we have responded to demand by increasing capacity within the service by an extra 4 days a week from an Independent Child Protection Chair who now specialises in LADO work as their primary role. This has provided the service with additional consistency. This change has been well received by partner agencies who have appreciated the consistency of service. It also provides additional expertise in the service and aids reflection and support to the service from having the additional expertise.

The service has remained mindful of the need for timely throughput as shown by the number of ongoing cases and timescales for completion and will continue to be mindful of the need to respond creatively to unpredictable increases in demand.

The data contained within this annual report are in the main unremarkable and reflect very similar patterns, year on year, with small accountable or explicable variations. This shows a consistency in threshold and response of which we are proud. One area of change relates to the incidence of "unsubstantiated" outcomes, and we continue to focus on reducing in the interests of clarity and better understanding for all around harm and risk posed.

We have sought feedback from partner agencies: this highlights our strengths and what needs to improve in our service. Again, we are proud of the feedback we have received which shows that our service responds in a timely way and provides quality responses to employers across a range of organisations who seek our advice. This feedback does also tell us that we need to strengthen our work with the police in some cases to ensure good communication and timelines of response and we have begun to address this.

Whilst we have continued to promote listening to children and their experiences at the heart of our work, the embedding of the Lundy Model and our learning from Quality Assurance activity continues to strengthen our child focus.

Finally, we will continue to be focused on whole organisation approaches considering patterns of concerns and learning for organisations overall where there are worries about individuals working within them. Follow the trajectory of the learning from the Doncaster investigations and National Safeguarding review, we understand the need to "think the unthinkable" and to be vigilant to the possibility of complex abuse whether in our own area or for "our" Leicester Looked After Children placed in other Local Authority areas.

8. Conclusion

We aim to

- continue delivering a quality service that has the confidence of partner agencies.
- ensure a process that is safe for children and fair for adults.
- to promote and support safe organisations.
- Learn and reflect and support organisations to do the same.

To achieve this aim:

- Our training offer will be regularly reviewed to ensure it is fit for purpose, relevant and reflective of updated guidance and new developments. Targeted training will continue to be available to the voluntary sector including sports settings, faith settings, services to children with disabilities, and to the private sector. There will be a targeted approach in the next year to promote training in settings children with disabilities attend.
- We will continue to dip sample and complete spotlight audits on LADO work monthly to ensure our aims are being achieved.
- We will continue our work with the children's engagement and participation service to gain a children's perspective and critique of our work and our quality assurance processes.
- We will share LADO learning from local and national reviews annually with children's social care and early help staff.
- We will work directly with police to strengthen our communication and processes.
- We will use our LLR Quality Assurance forum to focus on relevant themes e.g. managerless organisations and develop our knowledge base – we will similarly access learning via the regional LADO group and National LADO network.
- We will question all contacts to our service to establish if the individual of concern works "cross boundary" and liaise appropriately with other Local Authority LADO services.

Finally, we will continue to access professional development opportunities to develop our skills, knowledge, and expertise in order to continue to provide a quality service.

Jude Atkinson – Local Authority Designated Officer
Katherine Lockwood -LADO representative/Independent Chair
Lesley Booth – Service Manager
Safeguarding and Quality Assurance Unit

June 2024