Leicester LSCB Multi-agency Audit: Domestic Abuse 2018
Summary

This summary briefing presents the key findings/recommendations from the audit and is aimed at managers and practitioners working with children and families in Leicester. Please share this briefing with colleagues

Background

Working Together to Safeguard Children (2015) requires Local Safeguarding Children Boards to evaluate multi-agency working through joint audits of case files.

According to the NSPCC: *"Children who witness domestic abuse may:*

- *become aggressive*
- *display anti-social behaviour*
- *suffer from depression or anxiety*
- *not do as well at school - due to difficulties at home or disruption of moving to and from refuges".*

It is paramount for practitioners/services to consider the safeguarding risks posed to those children witnessing domestic abuse or living in environments where domestic abuse is present and for intervention to be effective. National and local reviews have identified the need for improving safeguarding practice in relation to Domestic Abuse. This led to the commissioning of a multiagency audit into Domestic Abuse to check compliance and seek assurance to the application of the LLR LSCB multi-agency safeguarding procedures; partner agency identification and response to cases where Domestic Abuse is a theme; identify learning to improve practice in safeguarding children and young people vulnerable to Domestic Abuse.

Methodology

The audit process used for this audit replicated that implemented by Leicestershire and Rutland Safeguarding Board (L&R SCB) to contribute to a joint approach and learning from the audit.

Seven cases were selected for auditing by the LSCB office from a list of cases provided by Children's Social Care. Although the cases were identified by one agency, the focus of the audit was to evaluate the effectiveness of the multi-agency response to safeguarding and promoting the welfare of the children in these cases. The audit was qualitative and completed by 31st May 2018. The audit report was presented to the LSCB Performance, Analysis and Assurance Group (PAAG).

Of the seven cases, five were audited by Children's Social Care and Early Help Service (three by Children's Social Care and two by Early Help). Four out of the seven cases audited by Leicestershire Police were within the scope of the audit. Five out of the six cases known to the GPs were audited (Clinical Commissioning Group). One case, selected for the audit was of an unborn child, and as such not registered with a GP and the pregnant mother was found not to be registered as a patient in LLR. Three cases from the seven were randomly selected by LPT for auditing (one out of the three was out of scope of the audit). One case was audited by National Probation Service (the others were not known or out of scope) and one by an education setting (out of the four education settings invited to participate), and none by UHL. In some agencies not all the cases were known or within the scope of the audit.

Further Information

- LSCB Website; LLR LSCB Multi-agency Domestic Abuse procedure: https://llrscb.proceduresonline.com/files/dom_vio_abuse.pdf
- Information and support: Helpline 0808 80 200 and http://www.leicester.gov.uk/your-community/emergencies-safety-and-crime/domestic-and-sexual-abuse/
- Police 999 (101); https://leics.police.uk/advice-and-information/victims-witnesses/domestic-abuse

Definition of Domestic Violence/Abuse

The Government's definition of domestic violence and abuse has been widened to include those aged 16 and over and now includes coercive control. The definition is:
"any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality. The abuse can encompass, but is not limited to:

- *psychological*
- *physical*
- *sexual*
- *financial*
- *emotional*

Controlling behaviour
Controlling behaviour is a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour
Coercive behaviour is an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.
This is not a legal definition.

The guide for local areas to consider how the extension to the definition of domestic violence and abuse may impact on their services:
"The Government definition, which is not a legal definition, includes so called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group"

According to the NSPCC, *"Living in a home where there's domestic abuse is harmful. It can have a serious impact on a child's behaviour and wellbeing. Parents or carers may underestimate the effects of the abuse on their children because they don't see what's happening".*

Key Findings/learning

- No concerns were identified at the audit discussion meeting regarding the children being left at risk or the immediate safety of those children whose cases were audited.
- Compliance to procedures was variable. There was evidence of compliance in some cases and agencies, but not in all cases across the partnership. In one case, there was evidence of the practitioner's *"…many unsuccessful attempts to liaise with the social worker, but no evidence that the practitioner sought advice around raising this as a concern"*. This issue could have been escalated for quicker response. In another case, the mother alleged FGM had taken place on her and her daughter, however, there was no evidence of consideration of the need to report this by the identifying agency as per national guidance. It was also unclear if medical assessments had taken place (as relevant) as part of the intervention by Children's Social Care.
- Accurate case recording was demonstrated across most cases and agencies, but not all, as issues were identified. For example, religion and language was not recorded in the demographic information (in one case). Meetings and tools used in assessment were not evident on a case record (research and tools were not used in all the cases audited). In two cases, the child was flagged on the GP records as being on Child Protection when following the Initial Child Protection Conference, they were not made the subject of a Child Protection Plan and were Child in Need (CiN). It was identified, that adults who pose a risk to the child(ren) should be flagged on the record, and that adults should be involved in the DASH risk assessment. The audit discussion group was informed that GPs are using UAVA to support them (where required) to complete the DASH assessment, and that other practitioners might also find this support helpful.
- Consideration of the lived experience/voice of the child was evident, but there were also instances where children's views were not sought/obtained suggesting that practice in this area needs improving.
- There was evidence of effective multiagency working. For example, there was multiagency representation at multi-agency meetings (CiN)/Reviews and clear and concise CiN reports received with key actions sent to partners in a timely way. Assessments and planning considered the child's SEN needs, the child's views were sought and life chances were improving. There was evidence of multiagency safeguarding planning (pre-birth assessments, core-groups, plans) for unborn children, where it was identified in the cases being audited, that the mother was pregnant.
- There were also instances identified where practice could be improved. For example, key contacts/agencies were not known by all the relevant agencies and all agencies were not invited to a multi-agency meeting, impacting on contribution to safeguarding planning. It was suggested that the coordination and administration process for Child Protection Conferences could be "SMARTER" to ensure that invitations are sent to the right people, including GPs. In one case an issue around the timeliness of core group meetings following the Child Protection Conference was also identified, despite the first core group date being set at conference. This issue should have been raised by the Chair of the Child Protection Conference at the next Conference. A single agency assurance activity is to be conducted on the timeliness of core groups and effectiveness of plans by the LA's Safeguarding Unit.
- Information sharing between agencies needs improving; One audit identified that information about a case heard at MARAC did not "filter" down to other relevant agencies. At the audit discussion meeting, the auditors queried:
  - How information on MARAC (i.e. where a case had been to MARAC) could be passed on to the Child Protection Conference Chair and possibly recorded on the on the child's case file?
  - Who amends the records of children with Children's Social Care where there has been a change in the child's GP?
- In one case, where the primary concern seemed to be CSE, the GP was unaware of the issue of domestic abuse.
- The school (in one case) were aware of some domestic abuse within the home but did not have direct contact or information about the work done with the family.
- Management oversight was evident in most of the cases and agencies. Contradiction between what was viewed as good management oversight and the quality of practice was identified (in one case). For example, the quality of assessment and safeguarding planning and the consideration of the child's views/lived experience was not considered 'good', but management oversight was, as there was regular supervision, both manager and social worker appeared to have good knowledge of the case, and there was evidence of oversight in earlier assessments. In another case, lack of engagement from the parents/family was identified and management aware of this, but it was unclear whether there had been any direction of how to move this forward or to escalate this issue.
- Use of interpreters where relevant and consideration of the child's culture was evident in some cases. Overall, diversity was not considered in the wider context such as exploring and gaining understanding of the child/family's heritage, culture, religion and community networks, and 'protected characteristics' as stated in the Equality Act 2010.

Recommendations: Partner agencies to ensure that there is greater awareness amongst practitioners working with children and families of the following to improve safeguarding practice in relation to domestic abuse:

- The need to comply to LSCB and internal procedures (including accurate case recording)
- Information known by the agency/practitioner in relation to domestic abuse must be shared with relevant agencies/practitioners involved with safeguarding children
- Information regarding the MARAC process and outcomes needs to be recorded on the case file and shared with relevant agencies/practitioners within the representative's agency
- Consideration of the child's lived experience (voice of the child) and that this is central to any safeguarding work with children and families
- Diversity and equality needs to be considered in the wider context
- Children's Social Care and Early Help Service to consider how to improve the administration and coordination of Child Protection Conferences so that the right people are invited to conferences and core group meetings are timely.