LSCB Domestic Abuse Audit (July 2017)

The focus of this audit was to independently examine the effectiveness of responses to children (and their families) where concerns have been reported in respect of their exposure to domestic abuse. It looked at agency responses and whether the cases showed examples of good practice or learning could be gleaned.

About the Audit

The LSCB commissioned an independent auditor to undertake this piece of work working with practitioners in a number of agencies and children and their families.

The audit entailed tracking agency responses to the needs of children and their families involved; examining responses/interventions; identifying good practice examples; exploring any cases where standards of practice were not met; gathering the views of children and young people and consulting with frontline staff. **Seven families were identified; nine children in total**. All the cases that were reviewed were 'live' within the last two years. The independent auditor also spoke to professionals involved in the Community Safety Partnership DA audit to inform key lines of enquiry.

What did the practitioners say?

The independent auditor spoke to practitioners who were involved in these cases. A standard set of questions was used relating to multi-agency working.

- Practitioners stated they used the LSCB threshold document on a regular basis.
- They agreed that the MARAC process worked well.
- All professionals stated that the work undertaken by the DAPS service was excellent.
- Work between BWA and CSC was viewed as positive.

What did the children and families say?

Two families (7 children) agreed to speak to the auditor

- All the children felt able to speak to someone at school if they were worried or felt scared.
- The eldest children in one family said they were able to speak to their social worker about any concerns.
- It was identified that one child was a young carer but there was limited local provision available.
- Both mothers were very positive about their experience with different agencies and the responses received.
- One mother expressed frustration that her children had to give evidence against their father.

Key Messages

- In the majority of cases agency responses were timely and appropriate.
- Practitioners showed a high degree of concern for the families and referred appropriately.
- Case notes showed that families felt responses were useful and helped them.
- Multi-agency working was found to be good on the most part.
- There was evidence that the Signs of Safety tool /framework was used in the majority of cases.
- All but one practitioner stated they were aware of the thresholds document.
- There was a lack of knowledge about local service provision for children affected by DA and practitioners often refer to national support services although they cannot provide the immediate emotional support.
- School staff often do not feel trained to deal with a child who is a victim or witness to DA.

The majority of cases audited met with or exceeded required standards of practice:

- A social worker argued to keep a case open until the partner (perpetrator) had engaged with support services and there was a review to check the intervention had significantly helped.
- Multi-agency working had ensured that timely and appropriate responses kept new baby and other children in family safe from baby's father.
- A Social Worker worked with a number of agencies (statutory and voluntary) so the family received the practical services and support they needed.

Cases that provide example for further Learning:

- Two of the cases highlighted the need for practitioners to use the escalation process which identified the need to raise the profile of the escalation policy by the LSCB and to encourage professionals to raise their concerns and make use of their designated/named safeguarding leads.
- The need to ensure all plans include SMART objectives to identify what needs to happen, by when and the outcome if not achieved.

Audit Conclusions

- Agency responses reflected practice guidance and best guidance in the majority of cases.
- There was good knowledge of the BF LSCB Thresholds document.
- There were procedures in place to ensure good outcomes for children and their families.
- Two cases were closed by CSC without other professionals involved being made aware.
- Lack of awareness by all professionals that they could refer children and families into other services.

Audit Recommendations

1. Partner agencies raise awareness of the revised Domestic Abuse Guidance when it is re launched and disseminate it as widely as possible to ensure all practitioners are aware of what services are available and how to access them.

2. A 'Domestic Abuse Pathway for Practitioners' to be developed and disseminated to all Partner agencies to include reference to the escalation procedure for professionals.

3. Review Domestic Abuse Triage in the MASH to examine information sharing protocol with early years' providers and the use of Berkshire Women's Aid to review lower level concern cases.

4. Embed Signs of Safety into Thresholds for Intervention Document.

5. Review Young Carers Assessment and service provision.

6. Review Domestic Abuse training as part of the Training Needs Analysis commissioned by the LSCB.

Following on from the audit recommendations; what can we all do now?

Ensure you are familiar with thresholds document and animation

www.bflscb.org.uk

Whilst working with the family ensure plans have SMART objectives

Ensure your agency is familiar with the new DA Practitioner Guide

www.bflscb.org.uk/links and publications/domestic abuse

Be sure your agency is familiar with the escalation procedure for professionals.

www.bflscb.org.uk/links and publications

Ensure all relevant staff receive domestic abuse training.

www.bflscb.org.uk/training

Ensure a family's commitment and capacity to break 'toxic' cycles of behaviour has been fully reviewed before de-escalation

Glossary

BF	Bracknell Forest		
BWA	Berkshire Women's Aid	LSCB	Local Safeguarding Children Board
CAMHS	Child and Adolescent Mental Health Service	MARAC	Multi-agency Risk Assessment Conference
CIN	Child in Need	MASH	Multi-agency Safeguarding Hub
CSC	Children's Social Care	SMART	Specific, Measureable, Assignable, Realistic and Timely
DAPS	Domestic Abuse Perpetrator Service		