Domestic Abuse Audit: Summary for Practitioners & Managers

December 2020

1 Background

The East Sussex Safeguarding Children Partnership (ESSCP) Quality Assurance (QA) sub-group is responsible for monitoring and evaluating the effectiveness of the work carried out by partnership agencies to safeguard and promote the welfare of children; and to make recommendations about ways this can be improved.

In December 2020 the QA Subgroup completed an audit on domestic abuse where there had been a referral and multi-agency involvement.

Domestic abuse is legally defined in the Domestic Abuse Act 2021. 'Abusive behaviour' is defined in the Act as any of the following:

- Physical or sexual abuse,
- Violent or threatening behaviour,
- Controlling or coercive behaviour,
- Economic abuse,
- Psychological, emotional or other abuse.

Under the Act, domestic abuse occurs where the victim and perpetrator are aged over 16. Abusive behaviour directed at a person under 16 is child abuse rather than domestic abuse. However, a child will be regarded as a victim of domestic abuse in their own right if they:

- see or hear, or experience the effects of, domestic abuse, and
- are related to the person being abused or the perpetrator.

2 Method

Six cases with multi-agency involvement were randomly chosen but reflected a range of disabilities, circumstances, age groups, location and outcome. Each auditor was sent an audit tool based upon the Ofsted framework. Auditors examined their agency records and discuss findings and to agree the learning, the strengths, the factors that supported good outcomes and the recommendations.

3 Strengths of Multi-Agency Practice

East Sussex Safeguarding Children Partnership

In the cases audited, there was evidence of:

- good, timely and effective response.
- Strategy Discussion being held within timescales in most cases with relevant professional.
- good coordination with MARAC
- beneficial and effective contact with the family.
- effective management oversight and reviews.
- good multi agency co-ordination, including effective collaboration between police, social worker, schools and SWIFT Specialist Services to identify risks posed to the child and create an effective plan to safeguard them.

4 Improvement in individual cases

While there was evidence of good multi-agency work in all cases, particular improvements in individual cases were identified, including:

- Strategy Discussions should always take place within 72 hours with a clear action plan in place and for the meeting minutes to be sent out within 5 working days.
- clear expectations to be set between the School and Social Worker to ensure information is shared between agencies and good communication.
- to always cover identity related issues in accompanying Family Assessment to explore what the impact is on the child and family of these factors in context of the risks and needs identified.
- to ensure key agencies receive updates at the end of the Family Assessment including sharing the assessment document with parental consent. Key partners including School & key health professionals to be told what the outcome of the Family Assessment is.
- for School Health to document the voice of the child in their assessment. However, this could have been due to Covid and being unable to speak directly to the children.
- to not discharge a child before completing a Health Needs Assessment even if there are concerns around consent.

5 Learning Identified

- The importance of always covering identity related issues in accompanying Family Assessments, to explore what the impact is on the child and family of these factors in context of the risks identified and generally.
- The importance of uploading the EHCP onto Liquid Logic to allow professionals to identify the child's needs quickly.
- Ensuring that case recording systems are updated in a timely fashion to prevent delays in decision making.
- More information needs to be recorded on GP's case management system in relation to safeguarding.
- The importance of a successful working relationship between a social worker and school and the impact this can have on the outcome of the child and family.
- To ensure key agencies receive updates at the end of the Family Assessment including sharing the assessment document with parental consent. Key partners including School & key health professionals to be informed of the outcome of the Family Assessment.
- School Health were not able to attend all Strategy Discussions meaning they had missed opportunities in identifying if there was a need to undertake a Health Needs Assessment, which in turn means they could miss opportunities to identify unmet health needs of the child.

6 Recommendations for improvement

- Primary Care to complete a piece of work to understand why safeguarding documentation / record keeping is lacking and to develop a plan to bring about improvements in practice.
- A child's EHCP should be uploaded onto Liquid Logic inform decision making.
- All direct allegations of domestic abuse result in a Strategy Discussion at the earliest opportunity. If there is a delay an explanation must be provided and recorded on Liquid Logic by the Practice Manager.
- All training should be updated with a focus on the importance of always covering identity related issues in accompanying Family Assessments.
- School Health to review their interim arrangement and develop a longer-term plan about attending Strategy Discussions due to missed opportunities in identifying unmet health needs.

7 Learning for practice

The ESSCP invite you to discuss some of the issues raised in this audit in your team meetings or during group supervision. We encourage your responses to be included in your team minutes and forwarded to the safeguarding lead within your organisation.

Points for discussion:

- What is your understanding of a non-accidental injury?
- Do you know what Video Interaction Guidance (VIG) is?
- How do you engage with fathers and non-birthing partners?