Leicester LSCB Multi-agency Audit: Domestic Violence/Abuse (DV) 2016

Summary

This summary (briefing) is aimed at managers and practitioner working with children and families in Leicester. Information about Domestic Violence/Abuse and Key findings/recommendations from the audit is presented. Please share this summary (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.
- A multi-agency LSCB audit on DV was conducted in October/November 2016, 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 DV is a theme; identify learning to improve practice in safeguarding children and young people vulnerable to DV.
- The audit report will be presented to the LSCB Performance, Analysis and Assurance Group (PAAG).

Methodology

The audit process, sample and selection of cases, scope and audit tool was discussed and agreed by the LSCB audit group, which has representatives from the following agencies:

- Clinical Commissioning Group
- Leicestershire Police
- Children Social Care, Safeguarding Unit, Leicester City Council
- Leicestershire Partnership Trust (LPT)
- University Hospitals of Leicester (UHL)
- LSCB office

The audit included accuracy of case details, referrals and response and identification of DV and underpinning this was the 'Voice of the Child' and compliance to procedures.

Ten cases were selected for auditing and included those identified by Leicestershire Partnership Trust (3), Leicestershire Police (3), and Children's Social Care (4). Not all cases were known to the agencies conducting the audits. The audit was completed by 8th November 2016.

The audit was completed by: Safeguarding Unit (Children Social Care); School (Learning Services); Leicestershire Partnership Trust (LPT), Clinical Commissioning Group (CCG), University Hospitals of Leicester (UHL), Leicestershire Police. One case was not found on the GP record system and one GP practice did not complete the audit in time for the CCG. Eight cases were not known to UHL and in two cases no safeguarding issues were identified.

Further Information

- LSCB Website: http://www.lcitylscb.org/
- LLR LSCB Multi-agency DV procedure: http://llrscb.proceduresonline.com/chapters/p_dom_viol.html
- 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

As of March 2013, the term 'domestic violence and abuse' should be used. The Government's definition of domestic violence and abuse has been widened to include those aged 16-17 and now includes coercive control. The definition is:

Any incident or pattern of incidents of controlling, coercive or 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. This can encompass, but is not limited to, the following types of abuse:

- Psychological
- Physical
- Sexual
- Financial
- Emotional

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 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.

The definition includes so called 'honour' based violence, female genital mutilation and forced marriage, and is clear that victims are not confined to one gender or ethnic group.

In domestic violence this behaviour is viewed as intentional and is calculated to exercise power and control within a relationship. The adults may be, or have been, intimate partners, or family members regardless of gender or sexuality.

Regular or prolonged exposure to DV can have a serious impact on the child's physical, emotional and educational development and wellbeing, despite the best effort of the victim(s) to protect the child. The impact on the child is more likely to be exacerbated in families where there is substance misuse, mental health issues, personality disorders and any combination of these.

Key Findings

- Compliance to and understanding of LLR LSCB multi-agency procedures was poor in some agencies.
- The history of the child/family's involvement with agencies was considered, but not sufficiently explored in some cases to fully understand the child's lived experience.
- In some case files/recordings, religion, ethnicity and language were not noted. There was discrepancy in date of birth and spelling of names as well as recording information on the wrong report. In one agency which audited the 10 DV cases: *"At least 1 discrepancy or omission in the demographic data was found in all the cases audited".*
- Inconsistent practice in referring DV cases to Children Social Care.
- Decisions made by Children Social Care were not always fed back to the agencies, and this lack of response was not pursued by the referrers.
- There was a lack of escalation by agencies where a referral made to Children Social Care was declined by Children Social Care.
- The Voice of the Child was obtained and informed planning in some cases, but practice needs strengthening as there was too much focus on the adult. One child (2 year old) was considered too young to be spoken to. Children's lived experience, irrespective of their age, should be considered as poor practice in this area led to insufficient understanding of the child's experience.
- Interpreters were not used in all the cases where required (one child (4 year old) was considered too young to understand the circumstance). Whilst family/child's culture was considered in some cases, in one case greater sensitivity was shown to the adult's (mother's) situation resulting in potential risk to the children and inadvertently the mother's safety as the mother also had to protect the children within the home.
- The quality of strategy discussions was variable. In one case the strategy discussion was structured, clearly recorded with a SMART plan. In another the strategy discussion was not completed within time, there was minimum information in the case notes regarding the strategy discussion and a change of team manager resulting in a lack of management oversight. One key agency was not aware of the strategy meeting and subsequent S47 that had taken place and had not received feedback. In the audit group's view, partners also have a responsibility to request feedback from Children's Social Care.
- There were good examples of multi-agency working taking place between agencies, but this needs strengthening. There is limited involvement from other agencies when a single assessment is being progressed. Although partners often attend multi-agency meetings it is not always clear how they are fully involved in the planning for the safety of the child. According to one agency there was a lack of consultation with that agency as part of the single assessment, this negatively impacted on the quality of the assessment and subsequent planning.
- A significant issue reported in the audit is the lack of partnership involvement and sharing of information which supported and strengthened assessments. Although there was good evidence of assessments addressing risk, the assessment of risk was not sufficiently robust. In the DV assessments there was no supporting assessment in relation to the risk which the individual posed to families. Additionally there was little evidence of key partners such as the police informing the assessment in relation to agencies risk assessment of the individual.
- Information from a Serious Case Review practitioner event suggested that there may be a lack of understanding amongst practitioners that single assessments are actually multi-agency assessments, in which partner agencies should be involved.
- The use of the DASH tool is not mandatory across agencies and that a range of tools are available and used by practitioners which supports inconsistencies in practice. The tools used also did not follow through to assessing outcome. The view of the audit group was that a suite of tools agreed by the LSCB (and partners) is required for practitioners to use and that this issue should be taken to the Performance Analysis and Assurance Group (PAAG) for consideration.

Recommendations

1. Partner agencies raise awareness of the LLR LSCB procedures, including DV and Resolving Practitioner Disagreement and Escalation of Concerns.
2. Partner agencies have in place processes and management oversight to ensure that practitioners within their agencies are compliant with the LLR LSCB multi-agency safeguarding procedures.
3. Partner agencies ensure the voice of children/daily lived experiences is embedded in practice. Each child within the family should be spoken to and their views considered separately.
4. Partner agencies consider whether a suite of tools agreed across the partnership is required for identifying and assessing DV.
5. Partners need to support the production of a 'person posing risk assessment' (as this assessment then can be used to better understand the risk an individual may pose to children and their family) and also consider the development of a discreet person posing risk assessment focusing on the perpetrator.
6. LSCB and partner agencies to reinforce that single assessments are indeed multi-agency assessments and partner contribution is required to ensure a holistic view of the child and family circumstances.