



## **Report to Bromley Safeguarding Children Board, Quality Standards Committee 2010**

### **Multi-agency audit of 28 cases of children aged 1 and under and the application of the London Child Protection Procedures on Domestic Violence.**

#### **Overview Report**

##### **1. Terms of Reference**

This audit was undertaken by the Quality Standards Sub-Committee of the LSCB, as part of a rolling programme as set out in the LSCB Business Plan 2009-2011.

Twenty cases of children aged one and under or unborn who came to the attention of the police in 1 June 2009 – 30 September following reports of a domestic incident were audited. The cases were selected to represent a mix of:

- Ethnicity, age and gender
- professional and service involvements social care and health

The purpose of this audit is to determine the extent to which the London Child Protection Procedures on Domestic Violence and the Barnardos' Risk Assessment Matrix is being used to safeguarding children and achieve best outcomes for the children involved.

The audit will address the following:

- The use of the LCPP on Domestic Violence and the accompanying Barnardos' Risk Assessment Matrix (RAM) by agencies when:
  - sharing information/making a referral about a child and
  - responding to referrals/information.
- The use of the LCPP on DV and RAM in social care's response to referrals.
- The quality of information shared and referrals made using the RAM and Procedures
- The quality of the assessment, in particular whether good outcomes are being achieved for children who are victims of DV.

Emerging themes are noted at the end of this report and may provide a basis for further, more focused audit activity. The audit was conducted to ensure a clear focus on impact and outcomes, in line with the Ofsted full inspections of safeguarding and children in care, and to assist the Board with monitoring multi agency safeguarding practice and practice within specific agencies.

This overview report has been prepared by the BSCB Development Officer and the Audit Co-ordinator. The recommendations set out in this report will be developed into an Action Plan disseminated

## **Methodology**

The cases for audit were be drawn from Police Merlin Reports covering the period 1 June to 30 September 2009 where domestic abuse is report and where the child is unborn or aged one or under. The Merlin notifies when children are present/ involved when police are called to an incident. A selection of cases was identified by the Manager of the Police Public Protection Desk.

It was agreed by the audit group that a sample of approximately 10% of cases was to be used to ensure a maximum number of cases to consider of 30 and a minimum of 15. The police undertook a dip sample. The sample of cases selected were spread across post codes to ensure that cases from both west and east social care districts were included in the sample.

The number of referrals to the Primary Care Trust for children aged under 1 and pre-birth between 1<sup>st</sup> June and 20<sup>th</sup> September were 175. Of these 58 were not referrals, 39 were sent for information only and 78 were referrals. In September alone 28 referrals were made. Of these 8 were not classified as referrals, 4 were for information only and 16 were referrals.

The sample of cases considered number 27:

- Domestic violence incidents where the child is under one year old or unborn.
- Covered the period 1 June 2009 – 30 September 2009.

The auditors were Deputy Manager, Quality Assurance Unit for Children’s Social Care, Manager Public Protection Desk the Police, the Designated Nurse for Safeguarding for the Primary Care Trust. They are managers who are experienced auditors, using a multi-agency audit tool covering five areas of questioning, designed to identify thematic strengths and weaknesses, as well as individual quality of work issues. Each section within the audit was graded individually, as well as an overall grade on each case, using the grading system from Ofsted inspections, as follows:

- 1 = outstanding (used as overall judgement only, if all categories good or better)
- 2 = good
- 3 = adequate
- 4 = inadequate

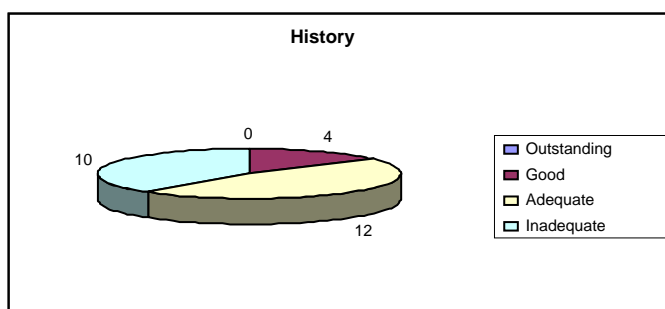
This system allows areas of good practice as well as areas of concern to be readily identified across agencies.

Judgement grades given by each of the auditors from different agencies auditing an individual case have been integrated to form one overall judgement for each area of work.

Any audits causing concern were referred immediately to managers for action. This occurred in one case for Children's Social Care.

## 2. Overview of each of the areas of analysis (Section 1 = Case details – no judgments needed)

**Area of analysis 2: History of Involvement:** - effectiveness of previous involvement?  
Appropriate identification of CP concerns and actions taken?



Previous agency involvement was adequate or good in 16 of 26 cases. Previous involvement was mostly confined to single agency intervention and often of universal service input such as health visitor visits or passing on information about voluntary agency support. In the majority of cases identified as inadequate, it was not clear what previous agency has been put in place. However, in a small number of cases appropriate involvement was identified as the apparent engagement of other agencies already involved with the family.

Positive features included:

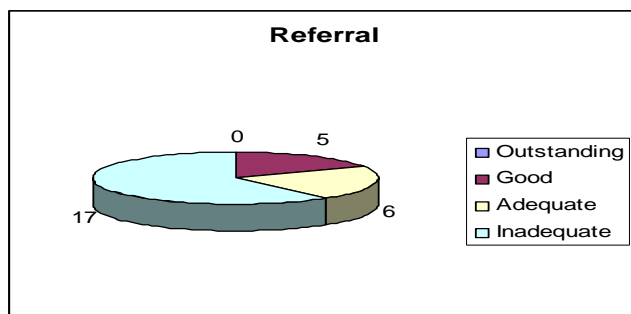
- Agencies were carrying out their required responsibilities as a single agency.
- Universal service support was identified in some cases.
- Some practitioners sought advice within and outside their agency about appropriate action (with some gaps).

The concerns in the 10 cases judged as inadequate were as follows:

- The lack of information about agency involvement.
- An apparent lack of information sharing regarding the family circumstances.

### Area of analysis 3: Referral

This section of the audit focussed on whether the referral was appropriate and whether the actions taken in response to the referral was appropriate including its timeliness and whether assessments were undertaken and strategy discussion/meeting held as required?



Procedures were not followed in 17 of the cases, highlighting concerns regarding awareness of the procedure and decisions around the adherence to the procedures. Children's Social Care took immediate action on several cases where it was deemed necessary for a Section 47 investigation to be started in order to safeguard the child. In five cases where good practice was seen the procedures were followed and multi-agency support was accessed. In one case it was appropriate for no assessment to be undertaken.

Positive features:

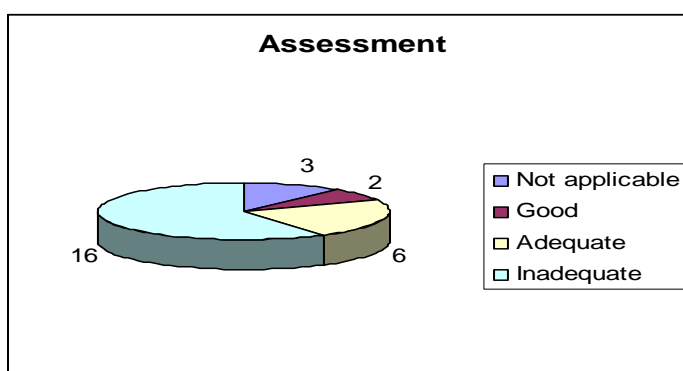
- Referrals were on the whole made at the appropriate time and the police referral form contained all relevant information, in particular noting if the child was present during a domestic incident and comment on the appearance and general safety and well being of the child. All police referrals are sent electronically to Children's Social Care Referral and Assessment Team. In two of the 27 cases the information about the child was not provided.
- Fourteen referrals made to the PCT did not arrive. It has been established that prior to the email transmission of referrals, they were faxed to the PCT. Unfortunately, there was no consistency in the referrals reaching the safeguarding team and it is assumed they went astray. Since September, referrals are emailed to the Name Nurse and the PCT safeguarding team. There is systematic receipt and logging of the details relating to the child on the PCT electronic records system, which is then follow up with appropriate health visitors. Where health received the Merlin report from police there was clear evidence of good multi-agency practice, contacting social care and visiting the family and directly addressing domestic violence. Within health, in one case, there was appropriate onward referral to the midwife with a special interest in mental health.
- In three cases, social care informed the health visitor of the concerns regarding domestic violence so that there could be appropriate follow up.

However, there were some significant concerns:

- The majority of cases indicated a trend of inappropriate response by Children’s Social Care. The failure to follow procedures and to use the risk identification matrix put children at risk of harm. In one case, along side the domestic violence incidents, was a history of mental health concerns. Had the procedure been followed and the matrix applied the unborn child’s needs would have been addressed more quickly.
- When an incident of domestic violence is referred there is insufficient checking of social care records. It appears as though each incident is treated in isolation. In one case, where there was a significant history of domestic violence between the partners, the case was identified as for no further action.
- In one case where there was follow-up on a referral, the history of a family was not sufficiently taken into account. Instead of initiating a Section 47, a Working Together Agreement was drawn up. This was inappropriate and vital opportunity to safeguard a child was not seized.
- It was not clear from the records whether feedback was provided to the police regarding referrals. However, the police are aware that they do not generally receive feedback.
- Where agencies are involved with a family and are unhappy with the outcome of a referral to social care, it appears that concerns are not often escalated.

#### Area of Analysis 4: Assessment/Procedure

This section of the audit considers whether appropriate actions were taken to safeguard the child? Were all checks made and agencies consulted? Was interpreter used if needed? Were children seen alone and views sought? Were risks clearly evaluated? Has the appropriate and an effective core assessment been completed? In this audit, consideration of the action taken on assessment and following procedure is inextricably linked to the section on referral. The inappropriate response to referrals is directly related to the failure to follow procedures, which was to conduct a full assessment.



In sixteen of the cases, no assessment based on Section 47 investigation was undertaken, despite the requirement for this based on the London Procedures. In three cases it where the cases was referred to an appropriate local authority, no assessment was required by

Bromley. In two cases good assessments were undertaken, because they were the appropriate assessment and the quality of assessment meant that the family history and child needs were taken into account sufficiently. In one case a child was already subject to a child protection plan, but no Section 47 was initiated on the report of domestic violence and therefore it was unclear how this information would formally contribute to the assessment of the child's needs and its safety. In one case a very good initial assessment was undertaken, which put appropriate child safety actions in place for the child, however, it was not the appropriate assessment according to procedure.

Positive features included:

- In one case the only assessment undertaken was the health visitor's pre-birth assessment of the family.
- There is evidence of multi-agency working despite the paucity of assessment. In three cases it is noted that the Health Visitor was alerted to the domestic violence incident by the social worker and that they made a contribution to the background information on the parent and family circumstances where known.

Areas of concern included:

- Where social care assessments were undertaken, there were gaps in the assessment particularly in relation to speaking with fathers, grandparents or other family members.
- Co-morbidity factors, such as mental health and substance misuse did not appear to fully inform decisions about the case.
- Complex family histories and previous notification of domestic violence were rarely fully taken into account.
- It was not clear from records held by social care whether strategy discussions were held.

### **Area of analysis 5: Management and Supervision**

Are front-line practitioners appropriately supported and directed? Are social workers regularly supervised, is supervision of good quality including analysis of risk, evaluation of progress, supervision decisions recorded, and supervisor present at key meetings? Is there evidence of consultation with senior managers?

The audit was conducted through the search of electronic records and it was not possible to determine in each case whether supervision took place or not or to see the record of supervision. This in itself highlights a need for electronic records regarding cases and their supervision to be systematically updated and a means of sign off that would give auditors confidence to be found..

From the case notes in a few cases it was possible to identify some evidence of good practice in health visitor teams as decisions taken make reference to what was agreed at supervision. The nature of the police operation means that there is an opportunity for daily supervision of cases, this occurs before a case is referred on to other agencies.

Again from some of the case records in social care it is possible to identify that weaknesses in case supervision was evident. In one case, the file was closed without investigations being undertaken. Overall the failure to adhere to procedures signalled a lack of management oversight, this had potentially serious implications for the safeguarding of the children.

### **3. Conclusions**

This audit identified key practice issues which need to be addressed particularly the adherence to procedures by the Children's Social Care in order to keep children safe. Evidence of working together was evident however improvements in information sharing systems have a significant impact on this important area of safeguarding.

In three out of 27 cases the auditor had to take immediate action to ensure follow up and to action an assessment by social care. In one of these cases the actions taken were in appropriate.

In the majority of cases the London Procedure on Safeguarding Children living with Domestic Violence was not followed. This has immediate implications for the safety of children in Bromley. A notification was sent to all managers to ensure that the Domestic Violence London Procedure was being followed.

Where assessments of families were instigated, it was not clear that social care spoke to the father and assessed the impact of the risk posed by or in two cases to the father. The quality of assessment was impaired by this.

Although any audit is bound to highlight areas of concern, auditors were asked to make general comments at the end of the audit form, and many took the opportunity to comment on good practice and high level of commitment from practitioners. Of particular note was the quality of referrals from the police and quality of multi-agency working by health visitors. Whilst there is some individual variation in the quality of police referrals, the overall quality of information provided was of a high standard, clearly addressing the well being and safety of the child. This indicates a significant improvement within a period of six months, when a multi agency group first looked at referrals from the police.

It is notable that prior to the establishment of secure email transmission of referrals to the Named Nurse for Safeguarding for the PCT, some children's files did not denote police intervention or that domestic violence was a known factor in the family. The faxed transmission of referrals was a flawed system.

Good practice was evident in how health visitors engaged with the police and social care in safeguarding children. Responses were prompt with HV actively making contact with social workers. In some cases, where an assessment was undertaken by social care health visitors were contacted.

#### **4. Recommendations**

1. Findings from this audit should be cascaded by managers to staff group, so that issues affecting the individual teams can be acted upon, and clear direction given about accepted standards of practice and compliance with application of the Domestic Violence Procedures, issued by the London Safeguarding Children Board.
2. The LSCB should review awareness and use of the London Domestic Violence Procedures among key partners in Health and Children's Social Care. This area of work would benefit from re-audit in 6 months time.
3. Children's Social Care must be reminded of the need to follow the London Procedures which have been adopted by Bromley.
4. Agencies should ensure that managers identify the training needs of the staff they manage and ensure their needs are met in order to deal with some of the issues identified through this audit. This includes
  - Children's Social Care front line staff knowledge of procedures and skill development in identification of child protection concerns; understanding the impact of abuse and neglect; assessment; direct work with children; working with resistant families.
  - Assessment training should continue to be rolled out with perhaps the inclusion scenarios based on domestic violence cases as a means of raising the profile of this area of safeguarding.
5. Good practice in strategy discussions and meetings should be identified and shared with agency managers.
6. The independent chair of the LSCB should discuss whether resourcing issues are affecting adherence to Working Together requirements.
7. Social work managers should ensure that the quality of assessment meets the required standard, including that fathers and other relevant family members are spoken to as part of the assessment, as part of their management oversight role.
8. The social care supervision policy should be reviewed to ensure it is fit for purpose, and requirements reinforced with supervisors of staff.

#### **AUDIT TEAM**

**Nicky Brownjohn**  
Designated Nurse Safeguarding Children  
Lead Auditor

**DI Dave Smith,**  
Bromley Police, Manager Public Protection Desk

**Susan Webb**  
Deputy Group Manager, Quality Assurance Unit, LB  
Bromley CYP Service

**Yvonne Onyeka**  
BSCB Development Officer  
Report Author

## **Terms of Reference**

This audit tool has been designed for cases which demonstrate awareness and use of safeguarding protocols and the London Child Protection Procedures. It covers progress from the point of referral /information sharing to children being assessed (Initial or Core assessment). It is to be completed by each of the agencies involved with the child in the safeguarding case, whether through making or responding to a referral, use of/ sharing of information, representation at case conference. It will provide an analysis of the effectiveness of the use of the London Child Protection Procedures on Domestic Violence and the Barnardos Risk Assessment Matrix. It will analyse the work carried out in safeguarding the child and promoting their welfare, both by the auditor's own agency, and on a partnership working basis. Analysis of equality issues should be integrated as appropriate within each section.

Each section should be graded, according to the following scale (used in Ofsted inspections):

Outstanding = 1

Good = 2

Adequate = 3

Inadequate = 4

Grading each section will enable areas of concern and areas of good practice across agencies to be readily identified.

## **Purpose**

The purpose of this audit is to determine the extent to which the London Child Protection Procedures on Domestic Violence and the Barnardos Risk Assessment Matrix is being used in domestic violence referrals.

The audit will address the following:

- The use of the LCPP on Domestic Violence and the accompanying Barnardos Risk Assessment Matrix (RAM) by agencies when:
  - sharing information/making a referral about a child and
  - responding to referrals/information.
- The use of the LCPP on DV and RAM in social care's response to referrals.
- The quality of information shared and referrals made using the RAM and Procedures
- The quality of the assessment, in particular whether good outcomes are being achieved for children who are victims of DV.

## **Methodology**

The cases for audit will be drawn from Police Merlin Reports, which notifies when children come to attention because they are present/ involved when police are called to an incident.

An audit sample of approximately 20% of cases to ensure a maximum number of 30 cases to consider and a minimum of 15.

Sample of cases should be post code sensitive to ensure that cases from both west and east social care districts are included in the sample. The sample should reflect the distribution of cases across the districts

The sample of cases will:

- Look at domestic violence incidents where the child is under one year old or unborn.
- Cover the period 1 June 2009 – 30 September 2009.

### **Actions**

Any audits causing concern must be immediately referred to managers for action.

### **Timescale for Audit**

The audit will be completed by 16 November 2009 and results reported to the BSCB Executive Committee.

Multi Agency Audit meetings will take place on: 5<sup>th</sup> November and 11<sup>th</sup> November 2009.