Multi-agency Audit on Lived Experience of Children and Young People who are Victims of Domestic Abuse

29th November 2021

1. Introduction

The Merton Safeguarding Children Partnership (MSCP) undertook a multi-agency audit on the lived experience of children and young people who are victims of Domestic Abuse (DA). The Domestic Abuse and Think Family (DATF) sub-group sought to *commission and deliver a multi-agency practice audit relating to Domestic Abuse from the point of view of children and young people who are victims of or have witnessed Domestic Abuse.* They delivered the audit via the MSCP's regular multi-agency audit programme, which is overseen by the Quality Assurance and Practice Review sub-group. The aim of the audit was for partners to identify key themes and learning from recent practice on domestic abuse, and to understand how well the child's voice features in DA cases. The QA subgroup will monitor any actions going forward.

2. Methodology

Multi-agency partners were asked to complete an audit tool on four cases (representing four children and young people) that were identified as involving DA. The cases were selected by Margaret Mansfield, Designated Safeguarding Nurse for the Southwest London CCG (Clinical Commissioning Group), in her role as Chair of the audit. Three agencies returned their audit tools (Central London Community Health [CLCH], Epsom and St. Helier Hospital, and Early Help). Seven agencies attended a multi-agency audit workshop session (Police, Epsom and St Helier Hospital, CCG, CLCH, CSC, IDVA, and Early Help). Each agency presented their key findings and then, as a group, agencies discussed what worked well and what could have been improved.

3. Good Practice - what worked well?

- **Agencies acted promptly to make referrals and escalate cases –** for every incident in all four cases, referrals were made, resulting in timely interventions.
- **Good inter-agency communication -** there was good inter-agency working and effective communication and information-sharing across the four cases, including effective correspondence with neighbouring boroughs.
- **Additional needs were identified, and further referrals were made -** one victim was identified as being at additional risk using a Bengali interpreter by a Health Visitor. Another victim had enuresis picked up by a school nurse. Interventions were put in place in both cases.

4. What could we improve?

- **Although referrals were timely, more robust, and intense intervention is needed –** a number of the children involved in the cases had been known to services for very long periods of time. Agencies in the workshop commented that strategies needed to be put in place to "stop the revolving door of referrals."

- **More needs to be done to ensure that all victim voices are heard fully so that the true picture of domestic violence within a family can be seen –** in one of the cases, the child's voice is not captured at all. Other victims have not been given the opportunity to be spoken to alone to establish the full extent of control and violence. Questions were raised amongst agencies about the absence of fathers on child records and the levels of control they are potentially exerting on a family.
- **More needs to be done to encourage parental engagement –** there was discussion amongst agencies around what happens next when a parent refuses support or intervention. It was highlighted that other Local Authorities have changed their language around non-engagement and do not accept it as a reason for closure. In the cases where parents have not engaged, or refused support, "the revolving door of referrals" has continued.
- **There needs to be assurance that the needs and voice of children within a family are met and heard before a case is closed –** it was established during the workshop that one case was closed too early. Agencies discussed the issue of services being stretched and overwhelmed as well as judgements being made about the class and profession of family members.

5. Conclusions

Overall, agencies concluded that these cases provided evidence of good multi-agency working, where agencies acted swiftly to intervene and make referrals. However, it also highlighted some learning around how agencies could have provided more intensive intervention with families to stop the cycle of violence and conflict. There were also questions around whether there could have been more opportunities to undertake routine enquiry and maintain professional curiosity.

6. Next Steps/Recommendations to address the areas above

1. The MSCP should promote the Parental Conflict e-learning more widely to address more robust, intensive intervention with families. It is recommended that the MSCP undertakes targeted promotion of this training with team managers and in regular communications such as the MSCP news bulletin and website with a view to increasing the number of multi-agency practitioners trained.
2. The MSCP to write to CLCH seeking assurance that they are including routine enquiry in their practice so that all victim voices are heard fully, and when they are unable to include routine enquiry in the home (i.e., if the aggressor is around), they share information with the GP at liaison meetings to ensure that all contacts provide an opportunity to see the victim in a neutral place. The health visiting (HV) service will encourage the service user to engage with the children's centres / HV service and use routine enquiry at future contacts.
3. Professional curiosity to form a golden thread in practitioners' practice, especially where domestic abuse is a factor. To achieve this, the MSCP Policy and Training Subgroup should consider training and resources on professional curiosity.
4. Review of pathways to be undertaken to determine appropriate signposting of support at point of referral.
5. Seek assurance from CSF that non-engagement or refusal for support does not result in the basis for referrals being closed, and that other options are explored with the families.
6. The MSCP to seek assurance from partners through Section 11 on effective management of caseloads and;

7. Consider the appointment of a specialist team of workers who will support with Domestic Abuse across the continuum of need to offer robust, intensive intervention to families.
8. Good practice and learning from the audit to be shared with the QA Subgroup, DATF sub-group and wider partnership.