Improving Local Practice
Key Messages from the Multi-agency Audit on Safeguarding Children Living with Domestic Abuse

BSCB carried out a multi-agency case review to assure itself of how well agencies were working together to safeguard children and young people who experience domestic abuse.

Historically, three disclosures of harm due to domestic abuse were made two years before the disclosure which triggered child protection arrangements. This child suffered in silence for two years. There were signs that flagged domestic abuse, however these were not directly probed and there was no assessment of risk. No referrals were made to specialist support services for domestic abuse or to social care and some of the referrals to other agencies did not adequately articulate safeguarding concerns. Good risk identification and quality inter-agency referrals may have secured appropriate support earlier and this is a focus for improvement.

Recent actions taken to safeguard this child indicate a responsive service with better awareness of the signs of domestic abuse and confidence in following procedures. The child was immediately believed and concerns were acted on. Information sharing by one agency in particular was thorough.

What we did well

1. Current practice on handling disclosures and knowing when to make a referral was good in this case.
2. Oxleas NHS Trust was systematic and methodical in making relevant checks and referrals to other agencies when safeguarding concerns were identified. There was good follow-up on referrals.
3. Police records demonstrate good practice in indicating how decisions had been made, which facilitates reflective practice.
4. The safeguarding missing children procedure was followed appropriately by agencies.
5. The voice of the child was listened to when the final disclosure of harm was made and it was acted on promptly and sensitively.
6. Staff safety was considered in the management of the case.

Key Actions Taken

7. Third party information received by agencies about possible incidences of domestic abuse is to be reported to the police.

Areas for development

8. Raise awareness about the signs of domestic abuse with GPs and other professional to support early identification and action on safeguarding concerns.

9. Agencies to review referrals to other agencies to ensure they are clear about the presence of any safeguarding concerns. This supports receiving agencies to assess effectively and make appropriate interventions, including where there is a requirement for interpreters or other communication challenges.

10. Agencies to remind staff of the role of the CAF in assessing need and in bringing together agencies information to support a family at an early stage. This is likely to have led to earlier intervention for this family.

11. Language requirements of the parents were variously met. The use of interpreters should be consistent. Agency commissioners should ensure that interpreting services use staff who have been safeguarding trained and are aware of the confidentiality and sensitivity of the work.

12. Agencies to be reminded to check household composition whilst working with a family as part of ongoing risk assessment.

13. It would have been good practice to conduct an achieving best evidence interview with the child about what he had both experienced and witnessed at home.

Further Actions for BSCB

14. BSCB to share the findings of this case review with practitioners at a planned Safeguarding network event on 5th March 2014 and through the BSCB Newsletter.

February 2014