Partnership Audit on Domestic Abuse

in Preparation for the Joint Targeted Area Inspection (JTAI)

November 2016

Executive Summary

This audit was undertaken to assess the quality of our support to children and young people at risk from domestic abuse in order to drive developments in this area. It was also used to trial a potential methodology for partnership audits should we have a Joint Targeted Area Inspection (JTAI).

Six cases were audited which covered a range of ages and levels of need. Each agency audited their own agency's involvement based on the evidence on their case records against a common audit tool. They all made a judgement on the quality of partnership working. Agencies then discussed their findings and the audit process in a multi-agency meeting.

The audit findings are summarised below in terms of our strengths and areas for improvement.

Strengths:

- Children and young people are protected and were found to be experiencing good outcomes
- Identification of risk and response from agencies was swift and appropriate
- Information from other agencies is appropriately gathered within ChECS, resulting in families receiving the right level of support.
- All cases were found to be supported at the right level of need
- Families understood the purpose of plans and why services were involved
- Evidence of good multi-agency working, and information sharing between the core agencies
- MARAC was shown to be effective in supporting good information sharing and identification of risks for children
- Examples of good direct work and support to children and young people and their families
- Examples of appropriate challenge between agencies driving good outcomes for children
- Operation of the Domestic Abuse Hub as a central point of contact for agencies for support and information sharing

Areas for Improvement:

These areas are split into findings that we know are reflective of the practice within out wider system, findings specific to work on domestic abuse, and single agency areas for improvement.

Areas for improvement relating to the quality of practice within the wider system:

1. **Assessments and plans addressed the key presenting risks from domestic abuse, but did not always evaluate or address all the risks within the family, such as disguised compliance and parental substance misuse.**
2. **Permanency for children and young people needs to be a key consideration in planning from a much earlier stage.**
3. There were good examples of plans and assessments which incorporated the views and lived experience of children and young people. However, **we still have more to do to ensure the lived experience of children and young people is fully understood and reflected in all our work.**
   The LSCB will be launching an assessment tool for domestic abuse in February 2017 which will support practitioners to reflect on the lived experience of children living with domestic abuse.
4. **Wider family members need to be more involved in planning.** There were examples were protective family members could have been more involved in the planning process to strengthen the plan and support to the family, and perpetrators could be more involved.
   Cheshire East Council will be adopting Signs of Safety as our way of working within Children's Social Care in 2017, and this model requires that families develop a Safety Network of people to support them and the plan.
5. **Involvement from wider agencies, such as Housing, alcohol and substance misuse services, was not always sought**, and there were examples found were their involvement could have enhanced planning.
6. **All agencies need to be proactive in ensuring they have the full context for the family and understand the risks involved.**
7. SMART planning has improved, **but plans still need to be SMARTer, and the use of contingency plans needs to be improved.**
8. **Quality of case recording overall needs to be improved.** The majority of agencies reported that some information was missing from their records. The impact of the risks on the child/ young person, and the impact of the work on their outcomes, was not always evident within the assessment and the plan. This was often found to be documented elsewhere in the Children's Social Care and Early Help case management system, however this should be clearly evident within the assessment and plan so it is clear for the family, and it is evidenced that this has been evaluated by the partnership. For some cases, the quality of partnership working was strong. However, again this was not reflected within the assessment or the plan.

Areas for improvement specific to work around domestic abuse:

1. **Ensure pathways between ChECS, the Domestic Abuse Hub, and specialist domestic abuse services are robust and information is routinely shared to effectively protect children and young people.**
2. **Ensure that there is sufficient capacity within commissioned domestic abuse services.**
3. **Ensure guidance is available for professionals on what domestic abuse programmes are appropriate for parents to undertake**

4. **A case list of domestic abuse cases at early help to be sampled in order to establish whether the right cases are being classified as domestic abuse.**

5. **Review whether schools could receive copies of the MARAC minutes.**

Single agency areas for improvement:

Cheshire East Family Service:

1. **Sometimes families could not be allocated a Family Service Worker as the service was at capacity, which caused a delay in them receiving this support.**
   The full range of early help services will be mapped and a demand-led review of future provision requirements will be undertaken in 2017.

2. **Ensure all workers understand their role and responsibility to challenge other agencies**

CRC:

3. **Ensure effective management oversight arrangements are in place to ensure assessments and plans are reviewed and updated.**

Substance Misuse Service:

4. **Ensure effective management oversight is in place.**
   CWP already have a Supervision policy in place to make sure all clinical staff receive appropriate clinical supervision and management supervision. The service line manager needs to ensure the policy is adhered to and 'spot checks' will be requested by the service line manager to provide assurances that this is being monitored.

Barnardo's:

5. **Ensure effective management oversight is in place for pending cases.**
   Barnardo's will review their processes to ensure management review is in place for cases which are 'pending' (prior to engagement), as well those which are open, particularly with a view to management review being triggered by parental non-attendance at a programme which has been specified as part of a Child Protection or Child in Need plan.

Children's Social Care:

6. **Ensure managers follow up management directions to ensure these have been acted on to achieve improved outcomes for children and young people.**

7. **Ensure social workers communicate well with other agencies.**

8. **Review whether access for Adult Social Care to children's records and vice versa can be granted to aid information sharing.**

GPs:

9. **The named GP to work with GPs to ensure reports are provided to inform case conferences.**

Health:

10. **Health Visitors and School Nurses to liaise with GPs to ensure they are fully informed when children are on Child in Need Plans or CAFs.**

Context

Joint Targeted Area Inspections (JTAIs) are a new type of inspection which were introduced in April 2016. These are partnership inspections, which will assess our effectiveness as a local area in identifying and meeting the needs of children and young people under a specific theme. The theme from the beginning of September 2016 to the end of March 2017 was children living with domestic abuse.

The Cheshire East Domestic Abuse Partnership (CEDAP) Board and Local Safeguarding Children Board (LSCB) agreed that a multi-agency audit should be undertaken to assess the quality of our services against the JTAI framework in order to inform and drive improvements to our services to improve outcomes for our children and young people.

The JTAI framework includes the requirement for the partnership to audit between 5-7 cases selected by the inspectors during an inspection. The framework states:

> *The local partnership should evaluate the children's experiences using its own mechanisms while taking account of the scope of the inspection. The evaluations should assess the overall strengths of the practice and identify areas for development.*
> *If the partnership chooses, they may provide a summary of themes and any learning from across their evaluations.*

For the purpose of the inspection and this audit, the term living with domestic abuse includes: children who are currently living where there are incidents of domestic abuse or where there is risk of incidents of domestic abuse taking place; and children seeing or hearing domestic abuse outside of their home or witnessing the effects of domestic abuse on others.

This audit was used to trial a potential methodology for partnership audits should we have one of these inspections. Learning points from this have been identified and are included in the report.

Audit Methodology

The audit tool was developed from the tool used within LSCB multi-agency audits, and adapted to be specific to cases with domestic abuse in line with the areas of focus in the domestic abuse JTAI. The tool is included within appendix 1.

Six cases were selected from cases open to the Domestic Abuse Hub, cases open to Children's Social Care with domestic abuse recorded as a factor at assessment, and cases open to the Cheshire East Family Service at CAF were there were concerns about domestic abuse. These cases covered a range of ages and levels of need. A table of the cases and case summary is included within appendix 2.

Partner agencies were asked to check their records to see whether the child/ young person or parents were known to them, and if so to complete the audit tool detailing the quality of their work in relation to the impact on the child/ young person. The schools of the children and young people were contacted individually and asked to complete the audit. Auditors were asked to consider the last six months of their agency's involvement.

Auditors were given a three week period in which to undertake their audits and return their findings for collation. Some agencies were granted an extension on request. In the inspection agencies will only have five working days to undertake their audits and return their

joint assessment of the strengths and areas for partnership working for the selected cases. The returns from agencies for each case is given in appendix 3.

For each case, the findings from the individual partner audits were compiled into a single audit form showing the comments and judgements for each agency. A multi-agency meeting was held to discuss the findings from the audit and agree strengths and key areas for improvement. Feedback on the audit process was also sought during this meeting and is detailed below.

Learning for JTAI Multi-Agency Audits

There were a number of points highlighted for learning from this process:

- The multi-agency discussion was very valuable and highlighted a number of areas for improvement, which were explored effectively within the meeting allowing professionals to understand the barriers to good practice
- The audit was useful in prompting reflection and evaluation on service quality. The process prompted one agency, Cheshire Without Abuse, to complete a deep dive audit of 63 cases to assure themselves on the quality of their work. Cheshire Without Abuse have developed an internal action plan to drive developments within their service in response to the findings of their deep dive audit.
- Agencies struggled to return audits within the three week period, which meant that when the multi-agency meeting was held not all the information had been collated and agencies had not been able to review other agencies' submissions in advance.
- Agencies found some questions on the audit form confusing, e.g. whether a question on the plan should be answered for their single agency plan or the multi-agency plan. Agencies thought that additional clarification on some questions and an example of a good answer would be helpful and assist consistent completion of the audit tool.
- The audit tool was lengthy and it was agreed that a more outcome focused approach around the key areas of practice to prompt discussion and reflection would be more constructive and time efficient for future audits.
- The audit involved considerable administrative time chasing returns, collating information, and compiling the audit report, which is a significant consideration as time would be more limited within an inspection. It was felt that this exercise would have been extremely difficult to undertake within five working days and would need to be considerably condensed to be realistically undertaken in an inspection period.

During the multi-agency audit meeting it was agreed that a small multi-agency group would review and agree the audit process and audit tool in preparation for the next multi-agency audit on neglect and in preparation for a joint inspection.

Health suggested that in future audit reports, pen pictures of the case could be used in order to give context to the case and express the strengths and risks within the family. This is how health present their audits within their inspections to the CQC and these have been positively received by CQC.

Based on the learning points above, it is recommended that the revised audit process:

- Involves at least one day being set aside for multi-agency auditors to complete the case audits together. This will streamline the time taken to audit with the time used in the multi-agency meeting, and will ensure time is allocated to complete the audit. It will allow

professionals to discuss multi-agency practice in depth which was valuable in the multi-agency meeting.
- Reduces the audit tool to focus on 5 or 6 critical outcome-focused questions to guide evaluation of the quality of casework.
- Trials a reporting format for evaluating each individual case and adopts the pen picture presentation.

A proposal on the audit methodology for the neglect JTAI audit will be produced by the multi-agency group and will be presented to the LSCB Neglect Sub Group for agreement for the next JTAI audit on neglect.

Analysis – Case by Case Summaries

Case A

A is now four months old. While his mother was four months pregnant, she was assaulted by his father who she was in a relationship with at the time. The police attended the incident and referred this to ChECS, who spoke to mum and were reassured of mum's protection for her baby, as mum said she had ended the relationship, had moved in with her dad and was pressing charges. She was already in receipt of support from IDVA as a result of a previous incident before she was pregnant. Due to this, the case was referred to the brokerage service to ensure the appropriate support was in place for mum and the baby.

Three months later the family was re-referred to CHECS by the midwife as it appeared mum and dad had resumed their relationship, although were not living together. Mum later said she would not resume the relationship, but professionals were concerned as to how honest she was being about this. There were significant concerns regarding the father's criminal history of domestic abuse involving several previous relationships, and an assault on a 15 year old child. Mum minimised the risk that dad posed to herself and her baby, and did not believe he was guilty of the assault on the child although he had been convicted of this. Dad was being supported by the alcohol service, and his alcohol misuse is a factor within the domestic abuse. A strategy discussion was held and a Child Protection plan was put in place.

What worked well:

- **A is experiencing good outcomes**, he is being well cared for by mum and seems healthy and happy. He is currently having supervised contact with dad.
- **Identification of risk and response from agencies was swift and appropriate.**
- The **key risks were clearly identified** in the assessment and addressed by the child protection plan, which was clear and focused.
- Both **mum and dad were involved in planning and were engaged with the process**.
- **Good multi-agency communication**, including good information sharing and agency involvement which allowed for a timely response when dad did not attend his first assessment appointment with the substance and misuse service.
- The **Health Visitor attended the initial conference although the child was unborn**. This gave the practitioner a good overview of the case before they took over responsibility from the midwife.

Areas for improvement:

- **When mum was re-referred to Children's Social Care she was not re-referred to the Domestic Abuse Hub.** This was a missed opportunity for specialist support as mum had previously engaged well with the IDVA service.
- The plan was clear **but was not SMART** as it lacked clear timescales.
- **Contact arrangements were not confirmed at the Child Protection Review**, although this had been identified as an action and a priority at the initial conference, and given the level of concern priority should have been made to ensuring secure and safe contact between the perpetrator and the child.
- **The maternal grandparents who were providing a place of safety for mum and A, but were not included within the planning** and this was a missed opportunity. There was also no evidence that the risks to the maternal family from dad were considered while mum was residing there.
- Housing were working with mum to find her accommodation. They were only aware that the family were on a Child Protection Plan as this was reported to them by mum, and they did not know that this was due to domestic abuse or that there had been a MARAC. On receiving this information from mum, **the Housing Officer could have sought out more information from the Social Worker around the risks** but there was no evidence that this had taken place.
- **The GP did not provide a report to inform the case conference.** The named GP has raised this with the practice. It is thought that this was due to no automatic reminder being issued through the GP's case note system due to the initial conference minutes being stored in mother's notes as the child was unborn. They are going to review their practice system to ensure this does not happen in future.
- Mum was later referred to the Family Service for additional support once the child was born but **the service felt that they could have been involved earlier** while mum was pregnant.
- The Family Service were asked to support mum in undertaking the Freedom programme to support her to reflect on the risk to her and her baby from domestic abuse. There was no rationale for this included within the referral to the Family Service. In the multi-agency audit meeting, specialist domestic abuse services raised **concerns about whether the Freedom programme was appropriate was parents to undertake.** The Family Service also raised that they had not thought this programme was appropriate **but had not felt that they had the expertise or authority to challenge the Social Worker about this.** It was thought that the Freedom programme may have been recommended as there was **no capacity within the specialist commissioned domestic abuse services**.
- The **previous MARAC and core group minutes were not stored on the Health Visitor's records** as the family had been supported by midwifery services at the time of these meetings and they had not been transferred across, which meant this record was incomplete. Supervision had taken place with the Health Visitor, **but there should have been management challenge** regarding ensuring safe contact arrangements were in place for the child and that the minutes from core groups were stored on the health record.
- **The Police records were missing the CP minutes**.
- The Substance Misuse Service also reported that there was **no evidence of management oversight** for their involvement following referral to their service.

Overall the partnership thought the work on this case was good and was achieving good outcomes for the child.

Case B

B is 4 years old and has a twin brother. She has a slight developmental delay in terms of her speech and language. Her pre-school contacted ChECS immediately after mum reported to them that dad had assaulted her the day before, and that both children had witnessed this. Dad has a history of domestic violence with previous partners and has been previously charged and imprisoned. Mum minimised the risk from dad to herself and her children. Mum also had difficulty managing the children's behaviour. A strategy discussion was held and a Child Protection plan was put in place.

What worked well:

- The family has made progress, and **the plan has had a positive impact on B** and her brother in terms of their daily life and development. As a result of this they have been stepped down to a Child in Need Plan.
- The **referral was made immediately** when the pre-school became aware of the situation. From the initial referral there was a timely response from all agencies.
- **The risks were clearly identified at referral, and appropriate information was sought from the Police, Health, Education and the DAFSU**. The rationale for the decision was clearly recorded.
- **The initial planning for the children protected them from witnessing further domestic incidents.** The children were seen on a regular basis, and core groups and conferences were held within timescales. **The contact plan for the children to see their father was positive and worked well for the children.**
- The pre-school worked closely with B, **offering regular one to one sessions where she was able to talk about her lived experiences.**
- **The most recent plan is child focused.** There is a good picture of B's lived experience within the plan, from observation, direct work and feedback from people around her. Mum has multiple needs which could have taken focus away.
- There was **good engagement with mum by the pre-school**, who worked closely with her and ensured she understood the minutes and implications of the child protection conference.
- There was **good engagement and involvement from agencies**, from universal to specialist, and there was close liaison and information sharing between the IDVA and the Social Worker.
- **Appropriate challenge from the pre-school and Health Visitor** was made at core group meetings to ensure good outcomes were achieved for B, for example a challenge was made as to whether there been an observation of dad having contact with the children.

Areas for Improvement:

- The assessment clearly focused around the key issues of the domestic abuse that the child had witnessed and the current risk. However, the assessment also made reference to previous concerns about the mother's alcohol and cannabis use as well as some inappropriate sexual boundaries, and the MARAC minutes made reference to the father's drug use and ADHD. **The assessment did not assess if those issues remained a**

current factor for the parents and how this may impact on their ability to parent and protect their children, which limited its effectiveness.

- **B's views should have been sought to inform the assessment.** In an initial plan, it was documented by the Social Worker that **the child was too young to comment,** however, the child's twin brother had spoken about the incident to the pre-school teacher, which indicates that at 4 years old he has a level of understanding and can communicate what happens at home.
- Dad was in prison at the time the assessment was completed. The assessment made reference to dad's views about his offending behaviour but this was taken from the previous assessment and there was **no evidence of direct consultation work with him**. Dad was later involved and engaged in the planning process.
- The maternal grandparent were identified as protective, but due to the grandparent being on holiday there was no discussion about what support she offers and how this is impacts on the children. **She did not appear to be involved in the planning process, which was a missed opportunity.**
- **The plan did not address concerns of disguised compliance** that the Social Work Team Manager had identified, and was a key feature in this case. **There was a lack of evidence that workers challenged the family in relation to information shared by the Police** on the mother's possible drug use and allowing the perpetrator to reside in the home when the plan specified that he did not live with the children. This information was shared by the police in the confidential section of the meeting without the mother present which some agencies felt didn't support addressing the issues with the family. This case showed that **agencies were potentially being over optimistic in their assessment of the family.**
- **It was questioned as to whether drug and alcohol services should have been involved.**
- There was evidence of **a significant delay in the mother being referred to the Gateway programme.** Places on the programme were not available at the time of the initial CP conference. When the mother was offered a place on the Gateway programme at a later date (3 months later) she did not want to engage and didn't attend, causing a further 5 month delay to her receiving this support. Other specialist services, such as IDVA, closed their involvement with the family due to the mother being on the waiting list for the Gateway programme, despite the mother not actually being in receipt of support around domestic abuse. This was particularly of concern due to the documented reports by the Social Worker, education, and Police that the mother minimised the assault on her and the risk to her children.
- Due to changes in management within the Barnardo's service at this time, **management oversight of this case was not carried out which could potentially have prevented the delay in accessing the Gateway programme.**
- The Social Work Manager appropriately challenged the quality of visits to the children and suggested seeing them on their own, **but it was not clear if this advice was taken or if this was followed up by the Manager**.
- The plan has recently been stepped down to Child in Need. However, prior to this a recent Police report detailed concerns that dad was back in the house and using cannabis. This is particularly a concern as mum had still not commenced work on the Gateway programme and had received minimal support around domestic abuse. All agencies agreed that Child in Need was the appropriate level for managing the risk, but that close monitoring needs to be ensured in order to protect the children.

- **The CRC's assessment for dad was not up to date, and their plan was not reassessed in line with their policy following the Child Protection meeting. The case was not referred for management oversight within the CRC, which it should have been at Child Protection level.**
- **Poor communication from the social worker was reported**, which impacted on the quality and effectiveness of multi-agency work. On one occasion this was due to changes in social worker, which occurred on three occasions for this case. It was reported that a social worker had attended a core group meeting having very little knowledge of the case and the family. This impacted on the quality of the relationship with the family and the effectiveness of the plan.
- The Family Service noted that there were some longer gaps between home visits, sometimes when access was not gained. **Some visits out of hours or at weekends may have informed the assessment of risk for this case given concerns were raised from neighbours.**
- The referral from Children's Social Care to Barnardo's contained **minimal information** and the information that Housing received from Children's Social Care stated that the family were experiencing domestic abuse but contained **no details on the specific risks**. **Housing did not contact the Social Worker to gain more detail on the risks**, which potentially could have informed their judgement on the family's priority for social housing

Overall the partnership thought the work on this case required improvement.

Case C

C is 6 years old. Mum contacted ChECS initially asking for advice about her joint tenancy with her ex-partner (C's dad) with whom she had separated, and the concerns about domestic abuse (from dad) arose during this conversation. Mum reported that dad abuses alcohol to the point that he passes out, and that the children have witnessed this. They had been married for 10 years, so the children had been exposed to alcohol misuse and domestic abuse over many years. Mum also reported incidents were dad had been aggressive towards the children. As mum was seeking support to maintain her separation from dad, the family was referred to support from the Family Service at CAF. Mum was also supported by the IDVA service.

What worked well:

- The work with the family was good and **achieved good outcomes for the family**, with them being rehomed and living free from abuse.
- **Referral was made quickly to the Domestic Abuse Hub and Family Service**, and IDVA support was quickly provided for mum. Support was also provided from specialist service Cheshire Without Abuse. The referral clearly outlined the risks to the family.
- **Partnership working was strong**, particularly between the Family Service, Cheshire Without Abuse, school and IDVA, ensuring the family were supported throughout and relevant information was shared.
- **Dad attended the CAF meetings and shared his views and concerns**.
- **The quality of recording within case notes was good**.
- Despite the quality of the assessment and plan being poor, **the children were kept safe by ongoing direction and oversight from the manager within the Family Service.**

Areas for Improvement:

- There was **delay of just over a week in allocating a worker from the Family Service** due to the service being at capacity, which meant that the family experienced a delay in receiving a service.
- Housing were only notified of the case in December by Cheshire Without Abuse, and the referral from mum seeking support had been in August. They **were not given any detail on the nature of the risks** from domestic abuse, and the Housing Officer **did not follow this up to request more information**.
- **The quality of the plan required improvement. The CAF did not address all the risks identified within the MARAC**, and the plan was not robust enough. There were some concerns around sexualised behaviour, with the mother being clearly uneasy about the relationship a family member had with her eldest daughter. The mother talked about her concerns on several occasions to different workers, and this was discussed in MARAC and an action was put forward to discuss in more detail mothers concerns. This action did not form part of the initial CAF plan, and while there is evidence that workers spoke to mother regarding this, there was limited information about any work being undertaken with the child herself. There were recorded concerns about her behaviour by school and her self- confidence and body image.
- **Case recording within the plan and assessment was very limited and was poor quality.** Recording within the assessment and plan was limited and did not reflect the quality of the work completed with the family. Multiple children within the family were discussed in the plan and it was not clear who is who and what their individual needs were. **The CAF didn't reflect the needs and the views of C**, even though these were known to the workers and were discussed during meetings. Parts of the plan were unreadable due to scanning the document into the system. Outcomes for the children were not evidenced in the reviews. There was also no evidence of dad's involvement within the plan and assessment documents.
- The Family Service and Wirral Community NHS Trust **did not have up to date chronologies on their case records.**

Overall the partnership thought the work on this case required improvement.

Case D

D is 10 years old. Mum had a stroke in 2015. Following this the Family Service were working with mum and D around D's behaviour, anger management and appropriate friendships. In the past, mum had been a victim of domestic abuse from dad, which the children witnessed. A MARAC was held in 2010. Mum and dad are now separated. Dad had previously made threats to kidnap the children and had attempted to do so, and he has previous convictions for GBH and ABH, and is a daily cannabis user. D was supported at CAF.

What worked well:

- There was a **clear plan that was delivered within timescales and the outcomes of the plan were achieved.**
- One to one sessions were held with D and **her wishes and feelings were heard.**
- **Case recording of the work completed was clear with analysis on the impact of sessions.**
- The Adult Social Worker **considered the impact of the caring role for the young people** in the household as a result of mum's health needs, and provided information on young carers assessments/carers groups to support them

Areas for improvement:

- As the domestic abuse occurred in 2010, it was considered historical, **and information on the history regarding domestic abuse was not shared with CAMHS**. However, CAMHS felt that this information would have been important in informing their support to D as the previous domestic abuse was likely to be a factor which was impacting on D's current behaviour. **The CAHMS practitioner had not contacted the Family Service or Children's Social Care for further information as the CAF had been closed at the point of the CAMHS assessment.**
- There was **no evidence of a contingency plan** if the family did not engage with the CAF.
- **The current work on this case within the scope of this audit was not in relation to domestic abuse, which highlights an issue with case identification**. As this case was identified for this domestic abuse audit, it is likely that it would also have been identified if we had had an inspection.

Overall the partnership thought the work on this case was good.

Case E

E is 11 years old. Her and her family are Polish and have lived in the UK for five years. Mum does not speak English, and asked her daughter E to report the domestic abuse and attempted rape mum had suffered from dad to the Police. Mum later retracted her statement to the Police stating that she felt her and her husband could work out their issues between them. Dad later assaulted mum outside school, and a domestic violence order was put in place. The children were supported on a Child in Need Plan.

What worked well:

- **Referral from the Police to Children's Social Care was swift.**
- **ChECS considered the impact on E** as acting as an interpreter as well as the risks posed to her from the domestic abuse she had witnessed.
- **Mum was supported by a Polish speaking IDVA,** and consideration was given to her needs and the impact on her and her children in relation to her isolation in the community.
- **Dad had been engaged with and his views were clear**
- The poor **quality of the work was challenged by the social work manager** and this was evidenced in the case notes.

Areas for improvement:

- **Information from other agencies (except the Police), e.g. education and health, was not sought by ChECS at referral.** It is of note that this referral came in during the school holidays.
- **The assessment did not fully address or include all the information that had been disclosed to the Police or the discussion within the MARAC**. The social worker also commented in the assessment that the father (the perpetrator) was not a risk, but it was not clear how this conclusion had reached so early in to the assessment, and without a fuller understanding of why the mother has retracted her statement to the Police on two separate occasions. **This assessment did not look holistically at the needs of the family**, and there was no evidence that the social worker had considered any other parental factors that could have been significant to the episodes of domestic abuse and sexual assault, such as mental health, drug and alcohol use. Within the assessment

there was evidence of a lack of professional curiosity and questioning, with a lot of the evidence documented by the Social Worker being self-reported by parents and not tested out. The quality of this work was challenged by the social work manager and this was evidenced in the case notes.

- **There was no evidence in the assessment that E was spoken to alone and her views heard,** although her views were sought and informed the plan at a later date. During this conversation the child disclosed how frightened she was of her father, especially when he used alcohol. This was the first time her father's use of alcohol was mentioned, and **there was no plan around how this would be addressed despite the fact that it was clearly a contributing factor to the Domestic Abuse.**
- **The plan required significant improvement. It was very brief and did not adequately address all the risks involved, or make it clear what the expectations were of the parents.** The actions from the 3 MARACs did not contribute to the plan, and there was no evidence of these actions being reviewed, despite there being two further incidents of domestic abuse.
- **Key agencies such as IDVA and Cheshire without Abuse did not attend the some of the Child in Need meetings, and it was not clear if they had been invited to attend.** There was no recorded update of their involvement and how this was impacting on the child.
- **Recording on the impact of the plan was extremely limited with tasks just marked as 'completed', so the impact of the work on outcomes for the child could not be evaluated.**
- **Some multi-agency meetings took place without an interpreter.**
- **The family's needs in relation to the language barrier were not initially recognised and responded to the Police,** this was appropriately challenged by another agency.
- **Poor communication from the social worker was reported which impacted on the quality and effectiveness of multi-agency work.** The lack of communication from the social worker with other agencies was raised and challenged in the 2nd MARAC meeting, and the quality of the work improved following a change in social worker.
- Although management direction on the assessment and plan, and challenge around the quality of work was evidenced by the social work manager, there **wasn't evidence that the quality of the work had been discussed in supervision**, which could have been used to support and challenge the quality work in this case.

Overall the partnership thought the work on this case required improvement.

Case F

F is 13 years old. He lives with his grandparents in a family arrangement as mum could not care for F due to her alcohol misuse. Mum was previously a victim of domestic abuse from her partner, who was living with her and F at the time. Mum is now the perpetrator of domestic abuse towards her own parents (the grandparents caring for F). She has been convicted of harassment against them and served sentences in prison regarding this. F has been subject to a Child Protection Plan on three occasions, and has recently stepped down to Child in Need.

What worked well:

- **F is experiencing good outcomes, he enjoys living with his grandparents, and reports he is much happier there.** F understands why he lives with his grandparents and not mum, and F is able to access contact with mum.

- **F's grandparents are applying for a Special Guardianship Order** to achieve permanency for F.
- **F has attended meetings and his views and involvement were evidenced. The plan was centred on the needs and impact onF, including his level of resilience.** Grandparents have also been fully involved in the plans.
- **Multi-agency working was effective and there was evidence of good communication and joint decision making.** NPS (Probation) were fully involved in the plan, and health, housing and substance misuse services were also all involved in supporting mum.
- **The key risks to F and his grandparents were clearly identified and addressed in the plan, and a contingency plan was in place.** The quality of the Child Protection Plan was good.

Areas for improvement

- **Insufficient consideration was given to achieving permanency for F.** Given the longstanding nature of the risks, there should have been an earlier application for Special Guardianship Order (SGO) considered as it was apparent that mum could not provide the care needed for F in the long term. There was delay in achieving legal permanency as grandparents only recently applied for a Child Arrangement Order, and Court recommended they consider SGO, leading to further delay in achieving legal permanency.
- Regular management oversight was evidenced from the Children's Social Care manager, but there was **insufficient challenge around achieving legal permanency**.
- **F has been subject to a Child Protection plan on three separate occasions for similar concerns.** In the most recent episode of involvement, actions were taken in a timely way to safeguard F by moving him to live with his grandparents.
- **The Child in Need Plan was less detailed,** and did not refer to some direct work that was due to commence with F to support him to have a better understanding of his mother's addiction to alcohol. The plan also contained limited information regarding F's wishes and views.
- **There was no evidence within the Child Protection plan that mum's views and wishes had been sought while she was in prison.**
- **Contact arrangements with mum could have been more robust.** This has been addressed within the latest plan.
- **The chronology on Wirral's records was not up to date.**

Overall the partnership thought the work on this case required improvement due to the insufficient consideration given to achieving permanency.

Analysis – Thematic Areas

Responses from the multi-agency professionals were collated and analysed. Where figures are quoted these are the percentage of respondents who agreed that the statement was evidenced within their agency records. Responses were combined across the six cases. The full set of results are included within the appendix.

Four cases were judged to require improvement and two were judged to be good.

Impact for Children and Young People

Children and young people are being protected from domestic abuse, and are experiencing good outcomes. There was evidence that contact for children and young people was being considered which is positive, although in two cases the arrangements around contact could have been more robust.

Timely Identification and Response - The Right Service at the Right Time

Identification of need, subsequent referral, and response was shown to be timely for children and their families (82% auditors agreed). Relevant information from core agencies was sought and used to inform the assessment of need in the majority of cases (81%) which is consistent with other current audit findings on information gathering within ChECS. In one case, information from other agencies was not sought by ChECS at referral.

68% auditors agreed the views of children and young people were evidenced at referral, and 79% reported that the risks to the child were clearly identified. 92% reported management oversight of the referral.

All cases were found to be supported at the right level of need from the initial identification of risk. Intervention and reviews were generally found to be timely for families.

However there were some delays evidenced for children and young people:

- In one case, insufficient consideration was given to achieving permanency for the young person. Given the longstanding nature of the risks, there should have been an earlier application for Special Guardianship Order considered as it was apparent that mum could not provide the care needed in the long term.
- There was delay of just over a week in allocating a worker from the Family Service due to the service being at capacity, which meant that the family experienced a delay in receiving a service.
- There was evidence of a significant delay for one case in the mother being referred to the Gateway programme due to capacity with the commissioned specialist services. The freedom programme was also identified for one parent, which agencies felt was not appropriate, and it was thought this was due to a lack of availability of other support from specialist domestic abuse services due to capacity.

In one case the Family Service felt that they could have been involved earlier to offer support.

Information Sharing

Overall, this audit showed that between core agencies, key information about the family was shared which supported accurate assessment and management of the risks involved. MARAC was shown to be effective in supporting good information sharing and identification of risks for children. There were three cases which evidenced strong multi-agency working, good communication between agencies and information sharing.

Good practice in information sharing was found by Mid Cheshire Hospital Foundation Trust, who had received Child Protection documentation, even though they were not directly involved in the CP process, which was available for access if this became relevant so could have informed timely identification of risk.

However, some services, particularly Housing, were provided with less detailed information on the risks, which limited their ability to effectively safeguard. This was a feature in three cases. Services reported that they did not always have access to minutes of meetings that had taken place prior to their involvement with the family, particularly commissioned specialist services, which would have given them a better understanding of the needs and risks within the family. This highlights that both the quality of referrals to services required improvement in some cases, and that services need to be more proactive in requesting prior history and information.

In one case, when mum was re-referred to Children's Social Care she was not re-referred to the Domestic Abuse Hub, so the Hub was not aware the family was now open to Children's Social Care. This was a missed opportunity for specialist support as mum had previously engaged well with the IDVA service.

Access for Adult Social Care to children's records may also have improved information sharing and planning.

Schools do not currently receive copies of the MARAC minutes. Feedback from the MARAC meetings to the school on the risks and outcomes is provided by the Safeguarding Children in Educational Settings (SCiES) Team. It was questioned whether this is a duplication of effort and whether schools could be sent the MARAC minutes.

For one case, the GP did not provide a report to inform the case conference.

GPs were not always aware of when a child or young person was on a Child in Need plan or a CAF. It was agreed that Health Visitors and School Nurses involved in the cases should be responsible for liaising with GPs to ensure they are fully informed.

Assessing Risk

The findings showed that risks were clearly identified in the assessment (82%), assessments were timely (92%) and resulted in the right outcome for the child or young person (93%). Judgements on risk were informed by the use of specialist assessment tools for domestic abuse such as the DASH RIC (86%). 93% agreed that the information shared at MARAC had been used to keep the child safe. Specialist domestic abuse services were involved for all 5 cases where there were current concerns about domestic abuse.

Assessments and plans were shown to address the key presenting risks from domestic abuse and effectively protect children and young people from the immediate risks. However, assessments and plans did not always evaluate or address all the known risks within the family, such as disguised compliance and parental substance misuse.

Three cases highlighted that additional risk factors within the family, which were known to multi-agency professionals and were often evident within the MARAC minutes, were not considered in the assessment and plan:

- In one case there were some concerns around sexualised behaviour raised in the MARAC, with the mother being clearly uneasy about the relationship a family member had with her eldest daughter – this was not addressed in the CAF.

- In another case, the assessment did not assess whether previous concerns about the parents' drug use remained a current factor. The plan also did not address concerns around disguised compliance which was a key feature in the case.
- In the third case, factors which could have impacted on the domestic abuse such as mental health, drug and alcohol use were not considered.

This limits our ability to manage risk effectively and support families to achieve long lasting change.

The quality of assessments was variable, with some good examples and some cases requiring significant improvement, with one case showing an over optimistic view of the family from professionals and lack of challenge to them on evidence they presented.

65% auditors found that the lived experience of the child was clear within the assessment. The majority of auditors reported that assessments were up to date and current (89%), however there were some examples where this was not the case so practice is mixed and inconsistent. 70% found that family history informed the assessment, and 70% evidenced an up to date chronology.

Consideration of the risks to any linked children was not routinely evidenced, but it was not clear from the audit returns whether this was due to there not being any linked children to consider.

The Family Service noted that for one case visits out of hours or at weekends may have informed the assessment of risk.

Effectiveness of Plans

90% agreed that the plan addressed the key risks. Overall, plans were centred around the child (79%) and were SMART (79%). Contingency plans were less evident, with only 48%. Overall plans were reviewed within timescales (93%) and there was management oversight of the quality of plans (93%).

As highlighted above, plans did not always address areas of risks within the family and there was evidence of professional over-optimism within one case and potentially within another.

As with assessments, the quality of plans was also variable, with some good, child focused, clear, concise examples and some requiring significant improvement.

Understanding the Child's Experience

65% auditors found that the lived experience of the child was clear within the assessment; 79% found the plan was centred around the child.

There were examples of good child focused plans, and good direct work carried out with children and young people to obtain their views and wishes, for example the work undertaken by the pre-school with B.

However, a frequent finding was that the child's views and wishes were sought and were understood by professionals, and were evidenced through case notes, but were not evidenced within the assessment or the plan. This is a missed opportunity as it limits the effectiveness and focus of these documents in achieving outcomes for children and communicating why change needs to happen.

There were also two examples were the child or young person's views were not sought at the assessment stage, so did not inform the assessment. In one case, if this work had been carried out at assessment, information on the father's alcohol misuse would have come to light sooner.

41% reported that the needs of the child or young person due to their ethnic origin, religion and culture were considered, which highlights that this is an area for improvement.

Involvement and Engagement with the Family

Overall, immediate family members were actively involved in plans; 74% agreed that there was involvement from all significant adults within the assessment, and 74% agreed the family was involved in the plan.

However wider family members need to be more involved in planning. There were two cases were protective family members could have been more involved in the planning process to strengthen the plan and support to the family.

Perpetrators could also be more involved, this was particularly true when they were in prison during part of the intervention process. There were two cases where this was a feature and there was no evidence that direct consultation work had been carried out with them to obtain their views, although following release they were engaged within planning. 92% agreed the alleged perpetrator was held to account for their actions and offered support to change.

Families understood the purpose of plans and why services were involved (87%). In one case there was evidence of good engagement with the victim by the pre-school, who worked closely with her and ensured she understood the minutes and implications of the child protection conference.

There was evidence that where needs due to culture or ethnicity were apparent, these were considered, but not always met. In one case the mother did not speak English, consideration was given to her needs and the impact on her and her children in relation to her isolation in the community. However some multi-agency meetings went ahead without an interpreter. The family's needs in relation to the language barrier were not initially recognised and responded to the Police and this was appropriately challenged by another agency.

Quality of Multi-agency Working

90% auditors reported that the quality of multi-agency working was effective. Partnership working was generally reported as good quality, ensuring that families were supported throughout, with good communication between workers ensuring relevant information and safeguarding concerns were shared appropriately, particularly between the core agencies. There were three cases which evidenced strong multi-agency working, good communication between agencies and information sharing. Examples of appropriate challenge between agencies were found which drove improved outcomes for families.

As discussed earlier, there were examples were agencies needed to be more proactive in seeking additional information to ensure they understood the risks to families and could effectively safeguard. Additionally, all agencies need to ensure that all known risks are addressed through assessments and plans.

There were two cases were communication from the social worker was reported to be poor, which impacted on the quality and effectiveness of the work.

Quality of Case Recording

The quality of recording is an area for improvement. In particular this was a common theme for the Cheshire East Family Service (CEFS) and Children's Social Care, but it was also an issue across cases for other agencies. Some case notes contained very good content and analysis, but overall practice was inconsistent. Information was frequently detailed within the case notes, e.g. within notes of visits with families, but was not evidenced within the assessment or the plan. This limits the transparency of the assessment and plan for the family, and therefore limits their impact.

In one case, recording within the assessment and plan was limited and did not reflect the quality of the work completed with the family. Multiple children within the family were discussed in the plan and it was not clear what their individual needs were.

In some cases the quality of recording also made it difficult to evaluate the impact of the plan on the child or young person. For some cases, the quality of partnership working was strong. However, again this was not reflected within the assessment or the plan.

In one case case recording within the CRC was very limited and some entries were missing. A number of agencies reported that their assessments were out of date, and chronologies were often not up to date. Some meeting records were missing from agency files.

Management Oversight and Challenge

Management oversight was reported as evident at referral (92%), assessment (85%) and planning (93%). Appropriate management oversight was demonstrated in all agencies, and challenge from managers to improve the quality of work was also demonstrated. In one case, despite the quality of the assessment and plan being poor, the children were kept safe by ongoing direction and oversight from the manager within the Family Service.

However, particularly within Children's Social Care, the challenge from managers was not always evidenced as being followed up to ensure this direction resulted in improved outcomes for children. In one case there was insufficient challenge around achieving legal permanency from the social care manager.

There was also evidence of some gaps in management oversight:

- Barnardo's (commissioned domestic abuse service) reported that there had been some sickness absence and other gaps in management within their team, resulting in one case not receiving management review. If management review had been in place for this case, the delay in access to the Gateway programme could potentially have been prevented.
- In one case, the case was not referred for management oversight within the CRC, which it should have been at Child Protection level.
- For one case, the Substance Misuse Service also reported that there was no evidence of management oversight for their involvement following referral to their service.

Understanding of Support Programmes for Domestic Abuse, and Challenge from Agencies

In one case, the Family Service were asked to support mum in undertaking the Freedom programme to support her to reflect on the risk to her and her baby from domestic abuse. In the multi-agency audit meeting, specialist domestic abuse services raised concerns about whether the Freedom programme was appropriate was parents to undertake.

The Family Service also raised that they had not thought this programme was appropriate but had not felt that they had the expertise or authority to challenge the Social Worker about

this, however all agencies have a responsibility to ensure the right action is taken fro children and young people, and challenge is an important component to good multi-agency working.

It was thought that the Freedom programme may have been recommended as there was no capacity within the specialist commissioned domestic abuse services, however it raised that guidance may be needed to support professionals around appropriate support for parents in relation to domestic abuse.

Case Identification

One case (D) which was put forward for the audit by the Cheshire East Family Service was a historical domestic abuse case, with a MARAC carried out in 2010. The current work on this case within the scope of this audit was not in relation to domestic abuse, which highlights an issue with case identification. As this case was identified for this domestic abuse audit, it is likely that it would also have been identified if we had had an inspection.

Summary – Strengths and Areas for Improvement

The audit findings are summarised below in terms of our strengths and areas for improvement.

Strengths:

- Children and young people are protected and were found to be experiencing good outcomes
- Identification of risk and response from agencies was swift and appropriate
- Information from other agencies is appropriately gathered within ChECS, resulting in families receiving the right level of support.
- All cases were found to be supported at the right level of need
- Families understood the purpose of plans and why services were involved
- Evidence of good multi-agency working, and information sharing between the core agencies
- MARAC was shown to be effective in supporting good information sharing and identification of risks for children
- Examples of good direct work and support to children and young people and their families
- Examples of appropriate challenge between agencies driving good outcomes for children
- Operation of the Domestic Abuse Hub as a central point of contact for agencies for support and information sharing

Areas for Improvement:

These areas are split into findings that we know are reflective of the practice within out wider system, findings specific to work on domestic abuse, and single agency areas for improvement.

Areas for improvement relating to the quality of practice within the wider system:

1. **Assessments and plans addressed the key presenting risks from domestic abuse, but did not always evaluate or address all the risks within the family, such as disguised compliance and parental substance misuse.**

2. **Permanency for children and young people needs to be a key consideration in planning from a much earlier stage.**

3. There were good examples of plans and assessments which incorporated the views and lived experience of children and young people. However, **we still have more to do to ensure the lived experience of children and young people is fully understood and reflected in all our work.**
   The LSCB will be launching an assessment tool for domestic abuse in February 2017 which will support practitioners to reflect on the lived experience of children living with domestic abuse.

4. **Wider family members need to be more involved in planning.** There were examples were protective family members could have been more involved in the planning process to strengthen the plan and support to the family, and perpetrators could be more involved.
   Cheshire East Council will be adopting Signs of Safety as our way of working within Children's Social Care in 2017, and this model requires that families develop a Safety Network of people to support them and the plan.

5. **Involvement from wider agencies, such as Housing, alcohol and substance misuse services, was not always sought**, and there were examples found were their involvement could have enhanced planning.

6. **All agencies need to be proactive in ensuring they have the full context for the family and understand the risks involved.**

7. SMART planning has improved, **but plans still need to be SMARTer, and the use of contingency plans needs to be improved.**

8. **Quality of case recording overall needs to be improved.** The majority of agencies reported that some information was missing from their records. The impact of the risks on the child/ young person, and the impact of the work on their outcomes, was not always evident within the assessment and the plan. This was often found to be documented elsewhere in the Children's Social Care and Early Help case management system, however this should be clearly evident within the assessment and plan so it is clear for the family, and it is evidenced that this has been evaluated by the partnership. For some cases, the quality of partnership working was strong. However, again this was not reflected within the assessment or the plan.

Areas for improvement specific to work around domestic abuse:

1. **Ensure pathways between ChECS, the Domestic Abuse Hub, and specialist domestic abuse services are robust and information is routinely shared to effectively protect children and young people.**

2. **Ensure that there is sufficient capacity within commissioned domestic abuse services.**

3. **Ensure guidance is available for professionals on what domestic abuse programmes are appropriate for parents to undertake**

4. **A case list of domestic abuse cases at early help to be sampled in order to establish whether the right cases are being classified as domestic abuse.**

5. **Review whether schools could receive copies of the MARAC minutes.**

Single agency areas for improvement:

Cheshire East Family Service:

1. **Sometimes families could not be allocated a Family Service Worker as the service was at capacity, which caused a delay in them receiving this support.**
   The full range of early help services will be mapped and a demand-led review of future provision requirements will be undertaken in 2017.
2. **Ensure all workers understand their role and responsibility to challenge other agencies**

CRC:

3. **Ensure effective management oversight arrangements are in place to ensure assessments and plans are reviewed and updated.**

Substance Misuse Service:

4. **Ensure effective management oversight is in place.**

   CWP already have a Supervision policy in place to make sure all clinical staff receive appropriate clinical supervision and management supervision. The service line manager needs to ensure the policy is adhered to and 'spot checks' will be requested by the service line manager to provide assurances that this is being monitored.

Barnardo's:

5. **Ensure effective management oversight is in place for pending cases.**
   Barnardo's will review their processes to ensure management review is in place for cases which are 'pending' (prior to engagement), as well those which are open, particularly with a view to management review being triggered by parental non-attendance at a programme which has been specified as part of a Child Protection or Child in Need plan.

Children's Social Care:

6. **Ensure managers follow up management directions to ensure these have been acted on to achieve improved outcomes for children and young people.**

7. **Ensure social workers understand the need for good communication with other agencies.**

8. **Review whether access for Adult Social Care to children's records and vice versa can be granted to aid information sharing.**

GPs:

9. **The named GP to work with GPs to ensure reports are provided to inform case conferences.**

Health:

10. **Health Visitors and School Nurses to liaise with GPs to ensure they are fully informed when children are on Child in Need Plans or CAFs.**

Appendix 1: Audit Guidance and Tool

Multi-agency Audit on Domestic Abuse

Guidance Notes:

- The audit should review **how the work considered the child**. This also applies to those services whose core work is with adults.

- Please do not include identifiable data in the report – **please use initials instead of names** for the child/ young person and family members. Please make it clear what the relationships between people are – for example please use 'dad', 'step brother', 'Health Visitor' instead of PK. **Please give the unique ID at the beginning of the form for the child/ young person – this is given on the case list.**

- You should complete a **separate audit form for each child** in the audit and this should be from **your agency perspective** and from the details held in your agency's records.

- You should look back at the **last 6 months of your agency involvement.** For example, if you have had no involvement for the last 3 months, please consider the involvement starting 9 months ago.

- **Please give detail against each point**. We want to use this exercise to pilot how we would conduct the audit if we were to have a Joint Targeted Area Inspection. We will have a multi-agency meeting following the audit to agree a judgement on the quality of our work as a partnership for each case, so we need to understand what informed your judgement on your agency's work. **Please include what could have been done better.**

- **If you have answered 'not applicable' please explain why.**

- The audit asks you to make an **overall judgement** about the quality of the work of your agency for each section – please use the Ofsted gradings below:

    - **Outstanding** – practice that is significantly above the standards for their own and multi-agency working
    - **Good** – practice that consistently meets the standards for their own and multi-agency working
    - **Requires improvement** – practice that is inconsistent in meeting the standards for their own and multi-agency working
    - **Inadequate** – practice that fails to meet the standards for their own and multi-agency working

We would like to recognise and celebrate good practice, and there is a space for this to be identified at the end of the form, this includes any work from your own or another agency.

Case no (UIN)	
Agency completing the audit:	
Audit completed by (name and title):	

Quality of the Referral:

No.	Question	Response (Yes/No)	Comments on Quality of Work
R1	Was the referral timely for the child/ young person?		
R2	Was sufficient information collected so that the nature and level of the needs and risks to the child/ young person could be accurately assessed?		
R3	Was family history and previous agency involvement considered?		
R4	Were the views of the child/ young person considered?		
R5	Were the key risks clearly identified, including risk from domestic abuse?		
R6	Was the outcome of referral the right one for the child/ young person? Is there a clear rationale for the decision?		
R7	Is there evidence of management oversight of the decision?		
R8	Was the family in receipt of early help prior to referral, and if not should they have been?		

Judgement on the Quality of Referral:

Judgement	Comment on why this judgement was made
Please delete to leave one judgement: Outstanding Good Requires Improvement Inadequate	

Quality of the Assessment:

No.	Question	Response (Yes/No)	Comments on Quality of Work
A1	Is the assessment up to date and current?		
A2	Is there evidence that all relevant agencies were consulted in the assessment (including specialist services, e.g. adult services where appropriate)? Is there evidence that information from your agency and other agencies was appropriately shared?		
A3	Is there evidence of the child/ young person's views and involvement? Were the key concerns discussed with the child/ young person?		

	Is the lived experience of the child/ young person clear, and is it specific to them as an individual?		
A4	Is there evidence that the needs of the child/ young person due to their ethnic origin, religion and culture were considered?		
A5	Has the assessment involved all significant adults, including absent parents? Were the key concerns discussed with the parents and carers?		
A6	Did the history of all family members inform the assessment of need?		
A7	Is there a chronology? Is it up to date? Did it inform the assessment?		
A8	Are all the risks to the child/ young person clearly identified? Did the assessment consider key risk factors, e.g. neglect, alcohol or substance misuse, mental health, domestic abuse?		
A9	Was the appropriate risk assessment tool used, including those for domestic abuse, e.g. Risk Indicator Checklist (RIC – 24 questions)		
A10	Was the impact of the risks for all family members considered and recorded? • Child/ young person and siblings • Victim • Partner		
A11	Was the assessment completed in a timely way, and was the family supported while the assessment was taking place?		
A12	What was the outcome, is there a clear rationale, and was it appropriate?		
A13	Is there management oversight of the assessment?		
A14	Did the information sharing, discussion and action planning at MARAC make a significant contribution to the child's safety and wellbeing? Are the MARAC minutes stored on your case record system?		
A15	Was the IDVA or other specialist domestic abuse service contacted by your agency? (where appropriate – if not appropriate please put NA)		
A16	Was this case flagged as domestic abuse on your system? (please identify if your system cannot flag domestic abuse)		

Judgement on the Quality of the Assessment:

Judgement	Comment on why this judgement was made
Please delete to leave one judgement: Outstanding Good Requires Improvement Inadequate	

Quality of the Plan:

No.	Question	Response (Yes/No)	Comments on Quality of Work
P1	Does the plan address the key risks from the assessment? Is there evidence that the safety of children and the adult victim have been the priority in all interventions and planning?		
P2	Is the plan centred on the needs and impact on the child/ young person? Are the views and wishes of the child/ young person clear? Is there a clear understanding of their lived experience?		
P3	Was the plan SMART?		
P4	Is there a contingency plan?		
P5	Was the family involved and engaged in developing and delivering the plan? • Child/ren • Victim • Perpetrator Are their views evidenced?		
P6	Was the risk of involving the alleged perpetrator in meetings and interventions recognised and managed appropriately?		
P7	Is there evidence that the family understood the purpose of the plan and why services were involved?		
P8	Was the domestic abuse discussed with the victim?		
P9	Was the victim referred to specialist services?		
P10	Was the victim given the contact details for domestic abuse specialist services?		
P11	Was the alleged perpetrator held to account for their actions and were they offered support to change?		
P12	Was the risk the alleged perpetrator posed to any other linked children considered and actioned?		
P13	Were all relevant agencies involved in the plan?		
P14	What was your agency's role in the plan? Was this appropriate, and fulfilled in a timely way? Did your agency attend all relevant meetings in relation to this child/family? (e.g. CAF/CiN/CP/MARAC/MAPPA, other)		
P15	Was the effectiveness of the plan appropriately reviewed in a timely way?		
P16	Was the quality of multi-agency working effective? If no, was this challenged by your or another agency?		
P17	Is the plan having sufficient impact on the experience of the child/ young person?		

	Was there any evidence of drift or delays?		
P18	Was the casework at the right level of need? If the case was stepped down was this planned and appropriate? Is the rationale clearly evidenced?		
P19	Is there evidence of management oversight of the plan? Did the manager challenge and support progress against the plan appropriately? Were issues escalated appropriately were necessary?		

Judgement on the Quality of the Plan:

Judgement	Comment on why this judgement was made
Please delete to leave one judgement: Outstanding Good Requires Improvement Inadequate	

Quality of Case Recording:

No.	Question	Response (Yes/No)	Comments on Quality of Work
C1	Were the case notes up to date and clear about the work that had been undertaken, the relation to the plan and the impact on the family?		
C2	Were the details for the child/ young person and their family members fully completed, including their ethnicity, contact details etc.?		
C3	Was it clear who the victim and alleged perpetrator of the abuse was?		
C4	Was this a case where both parents or carers were allegedly perpetrating domestic abuse? If so were the responses to the harm caused appropriate?		

Judgement on the Quality of Management Oversight:

Please consider the evidence of management oversight, challenge support and direction at referral, assessment and throughout the plan

Judgement	Comment on why this judgement was made
Please delete to leave one judgement: Outstanding Good Requires Improvement Inadequate	

Judgement on the Quality of the Work Overall for your Agency:

Judgement	Comment on why this judgement was made
Please delete to leave one judgement:	

Outstanding Good Requires Improvement Inadequate	

Working Together Effectively:

No.	Question	Response (Yes/No)	Comments on Quality of Work
W1	Was your agency aware that the child/ young person was subject to a multi-agency plan?		
W2	Was your agency invited to contribute to the plan?		

Judgement on the Quality of the Work Overall as a Partnership:

Judgement	Comment on why this judgement was made
Please delete to leave one judgement: Outstanding Good Requires Improvement Inadequate	

Any areas of good practice identified (this could be in your own or another agency):

Any other comments:

Appendix 2: Cases Selected

Child or young person	A	B	C	D	E	F
Age	4 months	4	6	10	11	13
Male/Female	M	F	M	F	F	M
Ethnicity	White British	White British	White British	White British	Polish	White British
Area	Crewe	Macclesfield	Crewe	Macclesfield	Crewe	Crewe
Level of Need	Child Protection	Child in Need	CAF	CAF	Child in Need	Child Protection
Heard at MARAC	Yes	Yes	Yes, repeat	Yes, historic 2010	Yes, repeat	Yes

Appendix 3: Audit Returns from Agencies

Organisation/ Service	A	B	C	D	E	F
Children's Social Care						
Cheshire East Family Service						
The Police						
Wirral Community NHS Trust 0-19 Service						
Mid Cheshire Hospital Foundation Trust						
Cheshire and Wirral NHS Trust - Substance Misuse Service						
Cheshire and Wirral NHS Trust - CAHMS						
East Cheshire NHS Trust						
GP						
Education						
Probation – NPS						
Probation – Cheshire and Greater Manchester CRC						
Domestic Abuse Family Safety Unit						
Barnardo's (commissioned domestic abuse service)						
Cheshire Without Abuse (commissioned domestic abuse service)						
Youth Engagement and Youth Offending Service						
Adult Social Care						
Housing, Cheshire East Council						

Key:

Family known and audit form completed

Family not known to agency, or agency not involved in planning process, or agency involvement was outside of the time period covered by this audit

No return

Appendix 4: Collated Data from the Audit Returns

Area	Ref	Outcome	Yes	No	Total	% Yes	% No
Referral	R1	Timely referral	23	5	28	**82**	18
	R2	Sufficient information collected at referral	25	6	31	**81**	19
	R3	Family history considered at referral	22	7	29	**76**	24
	R4	Views of child young person considered at referral	15	7	22	**68**	32
	R5	Risk clearly identified at referral	23	6	29	**79**	21
	R6	Outcome of referral right for the child	25	0	25	**100**	0
	R7	Management oversight of the decision at referral	22	2	24	**92**	8
	R8	Early help given at the right time	22	2	24	**92**	8
Assessment	A1	Assessment up to date and current	32	4	36	**89**	11
	A2	All agencies contributed to assessment	29	10	39	**74**	26
	A3	Lived experience of child is clear within the assessment	17	9	26	**65**	35
	A4	Needs of the child/ young person due to their ethnic origin, religion and culture were considered	11	16	27	**41**	59
	A5	Involvement with all significant adults within the assessment	25	9	34	**74**	26
	A6	History considered within assessment	21	9	30	**70**	30
	A7	Up to date chronology	23	10	33	**70**	30
	A8	Risks clearly identified within assessment	28	6	34	**82**	18
	A9	Risk assessment tool used	18	3	21	**86**	14
	A10	Impact of risks considered for all family members	26	6	32	**81**	19
	A11	Assessment was timely	23	2	25	**92**	8
	A12	Outcome of assessment was right for the child	27	2	29	**93**	7
	A13	Management oversight of the decision at assessment	23	4	27	**85**	15
	A14	MARAC kept child safe	25	2	27	**93**	7
	A15	Specialist DA service contacted	16	0	16	**100**	0
	A16	Flagged as DA on agency systems	29	3	32	**91**	9
Planning	P1	Plan addresses key risks	26	3	29	**90**	10
	P2	Plan centred around child	23	6	29	**79**	21
	P3	Plan was SMART	22	6	28	**79**	21
	P4	Contingency plan	14	15	29	**48**	52
	P5	Family was involved in the plan	23	8	31	**74**	26
	P6	Risk of involving the perpetrator managed appropriately	19	5	24	**79**	21
	P7	The family understood the purpose of the plan	27	4	31	**87**	13
	P8	Domestic abuse discussed with the victim	24	0	24	**100**	0
	P9	Victim referred to specialist services	30	0	30	**100**	0
	P10	Victim given the contact details for specialist services	23	0	23	**100**	0
	P11	The perpetrator was held to account for their actions	23	2	25	**92**	8
	P12	The risk posed to any other linked children was considered	15	3	18	**83**	17
	P13	All relevant agencies were involved in the plan	26	6	32	**81**	19
	P14	Involvement of your agency was relevant and appropriate	35	4	39	**90**	10
	P15	Effectiveness of the plan reviewed in a timely way	27	2	29	**93**	7
	P16	Quality of multi-agency working was effective	26	3	29	**90**	10
	P17	Impact on the experience of the child/ young person	22	5	27	**81**	19
	P18	Right level of need	27	0	27	**100**	0
	P19	Management oversight of the plan	26	2	28	**93**	7
Case Recording	C1	Case notes up to date	35	2	37	**95**	5
	C2	Details for the family members fully completed, including ethnicity, contact details etc.	36	2	38	**95**	5
	C3	Clear who the victim and perpetrator was	31	1	32	**97**	3
	W1	Your agency was aware that the child was subject to a plan	33	7	40	**83**	18
	W2	Your agency was invited to contribute	31	8	39	**79**	21