Pan Beds Multi-agency Audit

Pan Bedfordshire Multi-agency Virtual Audit looking at current working practices due to COVID - under 1 year olds subject to a child protection plan for Neglect - August 2020

The audit focused on current working arrangements, what's going well, good/innovative practice and any learning. Newborn babies, premature babies and babies with ongoing health needs are particularly vulnerable. Neonatal professionals have a key role in identifying neglect.

Aims

The aim of the audit was to consider practice across the three local authority areas during COVID with the purpose of providing assurance on:

- What are the strengths in relation to the current working practices to identify risks and safety planning during COVID?
- What are the strengths of the assessment?
- Have any substance misuse indicators been identified??
- How has engagement been carried out with the family??
- What has worked well? Good ideas?
- Are there any areas of development??

Methodology

- Local Authorities identified six cases of under 1 year olds subject to olds subject to a child protection plan for Neglect were selected (two by each local authority).
- Prior to the day a set of questions were devised and circulated to all the organisations involved in the specific cases, and they were invited to attend the event. On the day each case was presented with a short verbal presentation offering historical and current information
- The virtual audit sessions were facilitated by the Chair of the Neglect group and the Board Business managers (who had no involvement in any of the cases). Members of the Neglect Group attended along with some of the practitioners involved in the cases.
- All participants were invited to ask questions, and to reflect on the elements of good practice and gaps at a practice, organisational or system level.

Agencies who took part in the Learning Review:

Central Bedfordshire Council Children's Services – Bedfordshire Clinical Commissioning Group – Cambridge Community Services - Luton Borough Council Children's Services – Luton Clinical Commissioning Group – Bedford Borough Council Children's Services – Luton and Dunstable Hospital - Bedford Hospital – Bedfordshire Police – East London Foundation Trust - Pan Bedfordshire LSCB Training Unit.

Key themes from the Audit;

- **Some good examples of creative virtual meetings and contact with families during COVID.**
- **We know from other audits and SCRs the lack of focus on fathers but better engagement with fathers during COVID.**
- **In some cases COVID had not interrupted partnership and safeguarding work**
- **No GCP2s were undertaken.**
- **Age difference between some of the parents and this has come up in other audits but was not explored to consider possible grooming, exploitation or control issues in this audit.**
- **Pre Birth processes needed to be more robust.**
- **Some examples of good and poor information sharing.**
- **Digital Poverty and evidence of families being supported with technology to encourage engagement.**
- **Gender, culture and diversity was not explored fully and the impact on the child not assessed.**
- **Lack of recording/assessment and analysis on some cases**
- **Communication issues and not using interpreters.**
- **Lack of engagement from a parent in some cases**
- **Some good evidence of engagement via virtual tools however it is recognised that this does not work for all families, blended approach needed for some.**

What are the strengths in current working practices to identify risks and safety plan during COVID?

The majority of cases managed to continue contact with the child and family either through virtual or face to face - One case identified that the relationship with the mother improved due to virtual contact – There was ineffective safety planning in the two cases – One had limited recorded information, risk of DA increased during pregnancy and was not seen as a priority – The same case had possible CSE issues identified, was open to early help but Health agencies did not feel this was enough but they did not escalate their concerns fully – A Children's Centre maintained contact with the one of the families - Parents of one child could dominate conversations and make it about them and not the baby so the Social Worker made it clear to them what she would like to explore during their visit.

Strengths of the assessment? Any good practice identified? Was a GCP2 undertaken? If not why not? If yes how was it managed and any evidence of multi-agency working?

No GCP2's were completed on any of the cases and not considered on 2 cases - A GP was unaware of the GCP2 tool in one case – On this same case the assessment did not have joined up thinking in relation to the risks posed to the child and was closed as the mother was engaging with the midwife - Some evidence that pre-birth, child and family and cognitive assessments were completed and the outcomes of these assessments were really positive.

Any substance misuse indicators identified? What engagement & support took place with the parent who misused substances? Did substance misuse increase during COVID? Was the impact of substance misuse on the child (ren) assessed?

In 3 cases there was parental substance misuse - Conflicting information in different agencies records about one mother having had and still misusing substances – One father was misusing alcohol and he presented as aggressive but no evidence of work done to address this. Same case was closed due to change of circumstances but unclear what these were, the majority of visits were virtual but not clear how the home condition was assessed before case closed at a critical point when a baby born – One father identified as importing drugs and possible cocaine use however professionals had not identified any drug misuse concerns.

Engagement with the young person/family during COVID? Any good practice identified?

The majority of parents engaged really well regardless of whether face to face or virtual visits done – Families were supported in the use of technology by professionals – Some parents accessed Children's Centre virtually to do activities - One case the mother would happily show the child to the Social Worker on her phone plus she was now phoning the Social Worker regularly but contact with the father had not been as successful – GP agreed to see a mother as and when she needed so she had someone to talk to face to face – Extended family were also used to facilitate contact with the child and parents - Video calls were helpful but if workers wanted to complete a thorough assessment it was difficult to undertake observations of the family dynamics or home environment – Better engagement with fathers.

What has worked well during this time? Good ideas?

A Social Worker felt that as a group of professionals everyone had worked really well as contact continued with the family throughout COVID - It was felt by health colleagues that there are more opportunities to attend meetings when they are held virtually as professionals such a GP's don't have to leave the surgery to attend - MARAC referrals continued to be submitted throughout lockdown - Innovative ways to carry out face to face visits in prioritised cases, such as using the garden and larger rooms - Families assisted/provided with technology to engage.

Areas of development or recommendations for learning & practice for individual, organisations, multi-agency?

The audit highlighted a potential for hybrid meetings – specifically relating to CP Conferences, where the family, Social Worker and IRO will be meeting face to face with family, but all other professionals will come in virtually. It was agreed that this will be explored further as a longer term solution to the broader engagement from agencies and service users – For one mother the impact of COVID on the court processes led to her withdrawing her statement – For one child a referral to children's services was made late, however there was a good reason for this – In one case 3 single assessments had been completed in a year but the historic issues were not looked it (including possible CSE/grooming) – Need to ask families what works well for them – Learning highlighted on one case to ensure that health colleagues are involved with the ICPC and are aware of the plan as they were unaware of the CP Plan at the time of the targeted antenatal visit.

Questions for the Boards

- **How has COVID affected engagement with families?**
- **Have there been any escalation of concerns during COVID about practice and decisions?**
- **Are practitioners asking if there are any financial issues for families during COVID?**
- **How are agencies ensuring case/personal supervision continues during COVID?**
- **How are agencies ensuring that assessments of families are thorough?**
- **Where there are concerns about living conditions how has the practitioner seen, monitored and supported the family in addressing this?**
- **How are agencies assured that families understand how to engage with services during COVID?**
- **Do agencies take trauma/ACES into consideration when there is a diagnosis of mental health? Can mental health and/or domestic abuse shield disguised compliance?**
- **How are the partnership using Family Group conferences in neglect cases?**
- **What has the impact of COVID meant for pregnancy, for example missed appointments relating to COVID or safeguarding concerns?**
- **Ongoing issues in health that systems not being available to other health providers – how can we improve this information sharing within health?**

Actions

- **Develop clear pathways for young people as parents.**
- **The Boards to assure themselves that agencies have addressed the questions above.**
- **Two cases caused concern and were taken back for immediate actions.**

For more information about neglect please visit https://www.nspcc.org.uk/what-is-child-abuse/types-of-abuse/neglect/
For access to the Pan Bedfordshire multi -agency child protection procedures visit https://bedfordscb.proceduresonline.com/index.html

Pan Bedfordshire Multi-Agency Virtual Audit - current MARAC cases - February 2021

This summary is for managers and practitioners working with children and families in Bedfordshire. Please share this summary with colleagues.

The audit focused on current MARAC (Multi-Agency Risk Assessment Conference) cases. 6 cases were selected based on;

- Having a child/young person in the household
- Had been presented to the local MARAC within the last 6 months
- Three of the cases were repeat referrals to the MARAC.

Aims

The aim of the audit was to review the quality of practice from organisational, multi/single agency perspectives and to provide an analysis of the effectiveness of individual organisations and collectively

Methodology

The three MARAC's identified six cases (two by each local authority). Prior to the audit sessions agencies involved in the cases were asked to complete an audit template detailing;

- Brief overview of the family circumstances
- What's gone well? How this impacted on the family/for professionals?
- What's gone well? What could have been better? Areas for improvement, actions & learning.

The audit sessions were facilitated by the Luton Business Manager (who had no involvement in any of the cases). Members of the Pan Beds Learning Improvement and Training Group attended along with some of the practitioners involved in the cases.

Definitions;

MARAC is a monthly risk management meeting, professionals share information on high risk cases of domestic violence/abuse and put in place a risk management plan. The MARAC aims to:

- Share information to increase the safety, health and well-being of victims/survivors, adults and their children
- Determine whether the alleged perpetrator poses a significant risk to any particular individual or to the general community
- Construct jointly and implement a risk management plan that provides professional support to all those at risk and that reduces the risk of harm
- Reduce repeat victimisation
- Improve agency accountability, and
- Improve support for staff involved in high-risk DA cases.

SafeLives provides general information on MARACs and quality assures MARACs nationwide.

Disruption – the act or process of stopping a perpetrators behaviour using legislation, targeted, persistent and robust safeguarding responses

Safety Plan – sets out measures to protect a victim (and their children) immediately and in the future.

Working Agreement - agreed plan of action with the parents based on the level of risk or need of the children.

Agencies who took part:

Bedford Borough Council, Central Bedfordshire Council & Luton Council Children's Services, MARAC & DA Leads – BLMK Clinical Commissioning Group – Cambridgeshire Community Services – Bedfordshire Hospital Trust – Bedfordshire Police – East London Foundation Trust – BeNCH CRC – BPHA Housing – Embrace – Queensbury School – National Probation Service- Victim Suppoort - Pan Bedfordshire LSCB Training Unit.

Themes from the audit

Young parents need to be seen as young people first.

Practitioners need to explore why victims do not engage.

Need for greater disruption of perpetrators behaviour.

Safety plans need to be recorded on C/YP's file.

Are wider family, relationships and support networks a protective factor in all cases? In some cases there was pressure from families on the victim to leave or return.

For a working agreement to be effective all family members need to be involved.

There was a lack of challenge, scrutiny and managing the risk in some of the cases.

What impact does the decision making have on the C/YP?

Cultural competency and attitudes was an issue in some cases as well as and the barrier of language.

There was a lack of knowledge and identification of the risks posed by honour based violence/abuse.

Exploration of whether the perpetrator has other children is vital and assess any risk to them.

Do we just look at the immediate risk rather than the long term impact?

In some cases 'Was not brought 'policy may have been helpful in thinking about impacts on the C/YP.

Some good information sharing between agencies but in some cases this might have overloaded the practitioners.

Good IDVA support/work in the cases they worked with.

Adverse Childhood Experiences/trauma for the majority of the parents e.g. child sexual exploitation, witnessing domestic abuse from their own parents.

Some victims chose not to engage with mental health services.

There were few incidences of Adult safeguarding being considered.

Significant age difference between the mother and father in some cases, also a theme in other Reviews and audits.

What's gone well?
Multi-Agency/Single Agency

Some assessments/work evidenced the views of the C/YP were sought.

Family history was included in some assessments.

Some parents and their children seen separately.

Some evidence of good management oversight

Recorded discussions regarding thresholds and the closure of cases.

Police made appropriate referrals.

Evidence of good multi-agency work in some cases.

Examples of Police trying to engage with children/young people.

Generally good information sharing between partners.

IDVA involvement in a number of cases was very positive – e.g. IDVA worked with college to support one young person.

Use of legal orders supported the victim & C/YP.

Police asked appropriately to undertake welfare checks when practitioners could not gain access to the family.

COVID meant a slight delay in moves to refuges.

Agencies shared information with each other that indicated that some of these couples were still in a relationship despite their denials.

MARACs reported good information sharing.

Some examples of Early Help and good engagement with the family.

In one case the hospital called the mother re a missed appointment and due to her reaction they contacted the Police to complete a welfare check.

GCP2 carried out on a number of the cases.

What could have been improved?
Multi-Agency/Single Agency

Families not always aware of what support was available to them.

Young parents not seen as young people first and therefore a failure to realise their competence/capabilities as parents due to their age.

Some young parents were being controlled by their own parents.

Practitioners lack of understanding/exploration of the pressures on victims to remain or return to the family home, especially when the pressures come from their own families.

Number of incidents where police attend and don't support the victim fully as they do not want to engage.

Work to engage the victim where they had mental health issues.

Outcomes of assessments/work not always shared across the partnership.

If practitioners are uncomfortable seeing the perpetrator alone then how is this used/analysed in their assessment of risk?

Examples of some good outcomes but then the victim and children/young people are subjected to further abuse, roller coaster of concerns.

How engaged are Housing in cases? One case the father kicked in the front door which was unrepaired for a week leaving the family vulnerable.

Some practitioners said it was hard to have an honest and open conversation with the victim regarding the perpetrator.

Decisions/outcomes at other safeguarding meetings need to be made available to the MARAC to ensure they make appropriate decisions.

Expected information from the GP was limited in all but one case.

Recognising that some victims of domestic abuse are also or were victims of child sexual exploitation.

Intergenerational complexity, culture and young parents and also the expectations around being Pakistani, Bangladeshi for example.

Some of the cases evidence lots of good multi-agency liaison but also many missed opportunities.

In one case the School kept pushing for information and felt the communication and inter-agency working was poor.

In some cases practitioners listened to but did not really analyse the children/young person's experiences or their mothers

Disruption of perpetrators needs addressing and a focus of work with families as currently missing in most cases.

Questions for the Boards

How can we encourage and empower victims to engage with services?

How do we improve the disruption of perpetrators across the partnership?

What support is offered to perpetrators to address their behaviours?

What can we learn from the disruption of CSE perpetrators and utilise similar approaches when dealing with DA cases, for example using dangerous driving offences?

What is our response to young people at risk of domestic abuse?

What support can victims/families expect at Universal level?

How do we perceive 15- 18yr olds?

How do we perceive young people as parents?

What are these young people's view and understanding of healthy relationships?

If English is not the first language then is an interpreter made available and are we confident in working with the cases?

Do agencies identify and assess age gaps between the victim and perpetrator?

Many perpetrators were in custody at some point so are these opportunities being fully utilised to engage with the victims and their children?

How confident are practitioners in talking about and to perpetrators about their behaviours?

For more information about MARACs and Domestic Abuse please visit https://bedsdv.org.uk/

For access to the Pan Bedfordshire multi -agency child protection procedures visit https://bedfordscb.proceduresonline.com/index.html