

Learning from Multi-Agency Case Audits

November 2015

This information sheet summarises the main learning points from recent Multi-Agency Case Audits carried out on the following themes:

1. **Child Sexual Exploitation**
2. **Domestic Violence**
3. **Injuries in Pre-mobile Babies**
4. **Neglect**

Why does the Northamptonshire Safeguarding Children Board (NSCB) carry out Multi-Agency Case Audits?

The NSCB has a statutory duty to oversee and monitor the work that agencies are doing to safeguard and promote the welfare of children and young people in Northamptonshire. One of the ways in which the NSCB does this is to conduct Multi-Agency Case Audits (MACA). These reflect and build on good practice and are used to further develop inter-agency work.

How are the Multi-Agency Case Audits carried out?

The NSCB Quality Assurance Sub-group is responsible for carrying out the audits. Usually six cases are selected at random that have an element relevant to the audit theme, i.e. where neglect, domestic violence, child sexual exploitation or injuries to a pre-mobile baby had a significant part in the case. The audits are carried out either as 'in-depth' audits where the case files are analysed in a meeting with relevant professionals, or as desktop exercises that examine all the documentation for that case.

What actions are taken once an audit is completed?

1. **NSCB shares findings with agencies** - the findings from the completed audits are shared with individual agencies through the Quality Assurance Sub-Group members.
2. **Agencies take action** - each agency is then required to identify all actions and improvements that are relevant to their organisation and ensure these are included in their own organisation's safeguarding development plan.
3. **Findings incorporated into training** - the learning needs identified through the MACA process are also considered by the Learning & Development Sub-Group to ensure that any gaps identified are included as part of either single or multi-agency training.
4. **Findings made available to all** - The MACA learning summaries are published on the NSCB's website: www.northamptonshirescb.org.uk/MACA and made available through this information sheet.

1. Child Sexual Exploitation Multi-Agency Case Audits – six cases audited in August 2014

Key learning points:

- There was little evidence of multi-agency communication and a lack of clarity about information sharing in relation to young people discussed as at risk of child sexual exploitation.
- Little evidence of Voice of the Child.
- ‘Gillick Competency’ applied without child sexual exploitation challenge.
- Disguised compliance - in several cases the word of the parents was taken as gospel with only the most superficial assessment.
- Lack of chronologies, genograms and ecomaps evidenced.
- Out of county placements for safeguarding that had the effect of isolating young people from family networks.
- Poor compliance with statutory and NSCB processes, for example, Section 20 placements must be legal and signed by person with Parental Responsibility.
- No consideration for Family Group Conferences evidenced.
- Cases subject to considerable historic drift and delay.
- Missing person protocol and domestic violence protocol was not considered in all cases.
- Cross-border working protocol was not well understood.
- Reactive rather than responsive interventions evidenced.
- No evidence of early indication of risk.
- Poor early identification of child sexual exploitation concerns.
 - Documentation in some cases went back to the young person’s childhood. It was evident that no early help, such as children’s centre support was utilised even though there was evidence this would have been appropriate.
- The social care records did not provide a chronology of past contacts starting with every contact from the point of referral.

Strengths

- Police and Social Care evidenced good communication.
- Evidence of improved services since the Northamptonshire Improvement Board was established.
- Child sexual exploitation now becoming recognised as a causation of sexualized presenting behaviour.
- Participants at meetings committed to improving outcomes for child sexual exploitation.
- Multi-Agency Case Review Meetings recognised by all as a positive way forward for improving communication and service delivery.

2. Domestic Violence Multi Agency Case Audits – six cases audited in November 2014

Key Learning Points:

- Lack of evidence of multi-agency assessments. Social workers are not consistently using the partnership to complete Core Assessments.
- Multi-Agency Risk Assessment Conference (MARAC) minutes not evidenced in social care records. There is evidence of MARAC minutes in health records.
- Self-reporting by parents is accepted as factually accurate. The research and theory of Domestic Violence is not being used to underpin professional judgement.
- During the completion of Core Assessments, intervention appears to be delayed until completion of the assessment.
- Delay in progressing the Common Assessment Framework (CAF) and issues escalate and threshold then met for Tier 4.
- CAF not considering all children e.g. in other schools no triangulation and a Think Family approach.
- Lack of involvement of absent fathers.
- Family Agreements used to address risks which are not a safeguarding measure.
- Area social care teams not following section 47 processes leading to a lack of multi-agency meetings.
- Children and Young People's Nurse (CYPN) role needs to be understood and there is a lack of understanding of the universal programme they deliver. CYPN needs to see children before completing conference reports.
- Schools not using the Children and Young People's Nurse to inform and consult on issues.
- It is not clear how Education record Multi Agency Risk Assessment Conference information on ONE system. There appears to be a lack of schools having this information.
- No Common Assessment Framework (CAF) footprint.
- Impact of parental behaviours on children needs to be considered by health visitors and covered in supervision.
- When children come into care, agencies need to be notified within 24 hours.
- Lack of evidence core group minutes sent to partners.
- Children and Young Person's Nurse needs to think family.
- It is not clear if Family Nurse Partnership (FNP) have mandatory domestic abuse training.
- FNP did not capture the voice of the child but there is reference to parent child interaction.
- Partners need to be informed of the Public Law Outline (PLO) and their contribution.
- Lack of joint visits between Social Workers and Health Visitors.
- Lack of awareness of Toxic Trio. • Lack of research and evidence based practice in all partners.

3. Injuries in Pre-mobile Babies Multi Agency Case Audits – six cases audited in May 2015

Key Learning Points:

- Overall there was a clear lack of involvement and assessment of fathers. There is a need for a robust assessment of parents to include parent capability.
- Professional judgement around the presentation of the family was highlighted; when a Family presents very appropriately, this may potentially cloud professional views from considering non accidental injury.
- Poor information sharing between Local Authorities was identified.
- Process of decision making needs to be clearly set out and documented.
- Consideration of Section 20 arrangements and appropriate viability assessments to be undertaken of family members for the suitability of the care for the child.
- Considerable delays in cases going to court were identified.
- Inaccurate recording of information – Records to set out clearly whether contact has occurred face to face and clearly recorded information regarding discussions / contact and issues around non-engagement with the family.
- Poorly recorded strategy meetings were highlighted with lack of clarity around actions going forward.
- There is a need to review the 'lack of tenderness' in parental handling. A desktop review is needed to look at the future family, where more children might be born into the family and further issues of handling are unlikely to go away after a Finding of Fact Hearing where no findings have been made against either carer/parent.
- There is a need for criminal photography at crucial points of cases. These photos need credibility in court.
- A lack of awareness of the Bruising Policy was highlighted as a missed opportunity.
- There was an overall lack in the voice of the child coming through in assessments and a general misunderstanding of how to achieve this with babies amongst professionals.
- There were examples of an overall assumption that fathers are to blame and an overall lack of questioning / challenge around the appropriateness of mothers suitability to care for the child.
- An overall reliance by professionals for a social worker to escalate. A misconception that the Child Protection Plan instils confidence that something is being done.
- Step up and step down processes are clear and better, but there is a need for all partners to support the work of children's social care or Safeguarding Children's Services.
- Consideration of domestic violence by father against mother was highlighted as a missed opportunity to protect both child and mother.
- Overall willingness for professionals to accept first explanation of injuries which is put forward.

4. Neglect Multi Agency Case Audits – six cases audited in October 2015

Key Learning Points:

- Evidence of drift and delay in a number of cases
- Lack of multi-agency participation in meetings. Strategic discussions often taking place over the phone.
- Lack of assessment of parenting capacity, especially in the light of age or learning difficulties of the child.
- Lack of multi-agency process for children with previous safeguarding needs when moving in and out of the county.
- Voice of the child (VoC) is either missing or when present the implications of what the VoC means is not taking into account and considered in assessment of risk.
- Individual injuries / disclosures are being recorded in isolation i.e. no evidence of a use of a chronology which would give the “bigger picture”
- Early Help / Catch 22 not utilised effectively
- Lack of clear record keeping, especially around decision making. Within a family, issues are often recorded in only one child’s file.
- Professionals often lack the confidence / knowledge to challenge decision making.
- Injuries / disclosures recorded but not investigated or escalated.
- Need for a discussion/referral with a paediatrician where children have injuries- category of neglect clouded judgement that physical abuse also taking place.
- Parental mental health not adequately recorded.
- In one case, children left with their mother in spite of significant mental health issues, and mother not attending mental health appointments.
- No evidence of use of [Neglect Toolkit](#).
- Limited evidence that professional support, supervision and guidance considered impact of chronicity of neglect on case management.
- No evidence that “Think Family” approach was considered when dealing with the terminally ill by hospital or hospice.
- Child with developmental difficulties left in unsafe circumstances i.e. child’s developmental age not fully considered
- Inappropriate Sexual Behaviour and statements not followed up.
- No clear recording of developmental difficulties
- Clear system of escalation required when vulnerable children do not attend medical appointments
- Lack of communication and information sharing between Early Years providers.
- Need for Early Years involvement in the audit process.

Neglect MACA continued:

Strengths identified:

- Some good evidence of partnership working
- Schools supportive of children and families
- Evidence of use of SMART plans
- Some good engagement with adult mental health services
- Evidence of use of contingency plans
- Off duty policeman and DHL delivery plan – excellent practice “above and beyond”.
- Evidence of good GP involvement
- Excellent bereavement support from school

Contact the Northamptonshire Safeguarding Children Board:

Phone: 01604 364036 or Email: NSCB@northamptonshire.gcsx.gov.uk

See latest child protection news on our website: www.northamptonshirescb.org.uk

Go straight to the MACA webpages: www.northamptonshirescb.org.uk/MACA

See the latest training opportunities: www.northamptonshirescb.org.uk/training

NSCB Online Child Safeguarding Procedures Manual:

<http://northamptonshirescb.proceduresonline.com/chapters/contents.html>

See the Section on Bruising/Injuries in Pre-Mobile Babies:

http://northamptonshirescb.proceduresonline.com/chapters/p_bruising.html

See the Section on Child Sexual Exploitation:

http://northamptonshirescb.proceduresonline.com/chapters/p_sg_cyp_sex_exploitation.html

See the Section on Domestic Violence:

http://northamptonshirescb.proceduresonline.com/chapters/p_dom_abuse.html

See the Section on Neglect:

http://northamptonshirescb.proceduresonline.com/chapters/p_lscbn_neg.html