

# 7 Minute Briefing – Domestic Abuse Audit 2018

Domestic abuse continues to be one of the most significant reasons for contacts to the Multi Agency Safeguarding Hub (MASH) about safeguarding concerns for Sandwell children. A total of 4130 cases have been reported between April - December 2017

**1** In January 2016, the government published guidance on a new inspection framework known as the Joint Targeted Area Inspection (JTAI). The theme for September 2016 to March 2017 was the response to children living with Domestic Abuse. In September 2017 a **report was published** that shared the findings from this JTAI programme

**2** Following publication, Sandwell Safeguarding Children Board (SSCB) convened a multi-agency meeting on Monday 13 November to discuss the key observations identified during the JTAI with a view to benchmarking Sandwell's response to domestic abuse against this. The discussions helped to inform the subsequent multiagency audit on Domestic Abuse which was undertaken on Wednesday 28 February as part of the SSCB multi-agency audit calendar for 2017-18. This briefing identifies the learning from this audit.

## Key assurance questions included:

- 3** Is there sufficient accountability or responsibility attributed to the perpetrator of abuse?
- Is there an inappropriate attribution of responsibility on the mother to protect her children or blaming her for the abuse?
- Does the case sample evidence that there is appropriate focus on the welfare of the child from partners?
- Does the case sample evidence that partners take into account the varying needs of individual children?

## Key strengths identified were:

- 4** Adult victims (in all cases this was the Mother) were supported, with appropriate interventions and services
- Children were understood and supported as individuals and it was clear that agencies were considering that children's experience and needs may differ within the context of responding to domestic abuse
- Areas of good practice identified by way of the social worker introducing different safety scales (within the signs of safety model) during the core groups for mom, dad and children to help mom understand that agencies were not attributing inappropriate responsibility on her to protect the children and they were recognising what is working well

## Key areas of development highlighted were:

- 5** Offender Managers to be invited to core groups to ensure there is an appropriate focus and accountability placed on the perpetrator for the domestic abuse
- The SSCB escalation policy to be used and / or use of the Independent Review Officer in cases of drift and delay
- Practitioners should consider referring children affected by domestic abuse for emotional health and wellbeing support via the Single Point of Access
- The therapeutic support pathway for children exposed to domestic abuse should be agreed and the capacity for current services to meet their needs reviewed as part of CAMHS transformation planning

## What can we do now?

- 6** Ensure you are inviting offender managers (from Police and Probation) to Core Groups
- If you are a Manager, ensure there is sufficient progress of the child's plan to prevent drift and delay of interventions for children
- Consult the regional safeguarding procedures to utilise the SSCB escalation policy if required
- Use the directory of resources for therapeutic services to ensure children with emotional and health needs receive the right support (once shared)
- To continue to ensure that victims of domestic abuse are not blamed for the abuse

## Next Steps:

- 7** Learning to be incorporated into Domestic Abuse training programme
- Learning from the audit to be widely circulated and the recommendations monitored by QPP