Case Sample

A multi-agency case file audit was conducted on 10 children and their families where there were parental mental health needs, substance misuse and domestic abuse present (the Trigger Trio). All cases had reached the stage of pre-proceedings for a Care Order to be granted by the Court.

Limitations to the audit

Not all agencies known to the families returned completed audit tools.
Information was not received from:

- Probation
- Women's Aid
- Housing
- Some GPs and Schools

Case statistics:

Of the 10 cases audited:

- 2 children had no Children's Social Care involvement prior to the Public Law Outline (PLO)
- 1 child had been on a Child Protection Plan 3 months previously
- 5 children were on a Child Protection Plan
- 1 child was on a Child in Need Plan
- 1 was an unborn with PLO instigated pre-birth

Child 4 - Reports of domestic abuse from mother should have resulted in action for the child. Observed injuries should have resulted in a joint home visit with midwife. Both MPFT and ASC acknowledged there should have been a conversation with father as the perpetrator to safeguard the child so not all the responsibility is placed on the victim. Police reported risk assessment were carried out for domestic abuse incidents and an adult protection referral and DARA completed for mother when it was known she was pregnant. Mother was open to perinatal mental health services, had disclosed domestic abuse and substance misuse. She disclosed domestic abuse to Maternity and she was referred to IDVA and signposted to Women's Aid. **Overall: Good with elements of RI**

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Support Services (Trigger Trio):

Of the 10 cases audited:

- 2 mothers and 2 fathers were known to With You
- 4 mothers were known to SDAS
- 2 fathers, 2 mothers and 2 children were known to MPFT

Overall Grades:

All audits were rated Good with some areas of Requires Improvement

Child 3 - GP to consider the impact of parent's deteriorating mental health and DA on the child. EAS advised by social worker not to take action once Child Looked After. A safe referral was made by GP for triage in Bee U. and there was appropriate signposting and referral. Missed opportunities in MPFT to Think Family and be professionally curious. West Mids. Ambulance no evidence call assessor asked about children living in home. 29 DA incidents recorded by Police. Some Child Risk Assessments missed although referrals made. DARA recorded as standard risk, reviewed and changed to medium. No record case discussed at PITSTOP. Could have escalated earlier from Early Help to Social Care. **Overall: Good with some elements of Requires Improvement**.

Child 2 – Known to EAS, due to go to court but attendance improved. Missed opportunity for child assessment with MPFT, 'Space for Conversation' meeting didn't happen but now conducted. Father (now deceased) known to MPFT for assessment following overdose, signposted appropriately. Mother self-referred to With You to reduce alcohol use. No contact was made with known social worker. No domestic abuse reports made to With You and MPFT. Police reported 10 Child Risk Assessments in relation to domestic abuse, DARAs and appropriate referrals made to CSC, discussed at PITSTOP. Mother self-referred to SDAS, but disengaged. Chronologies not used effectively to inform decision making. CP Plan was over optimistic, reliance on self-reporting from parents **Overall: Good, elements of RI**.

Child 1 - Multiple referrals were not acted on. There was an over-optimism on parents to safeguard the child. with an unexplained injury to the child whilst on CP Plan which didn't result in S47. MPFT undertook unannounced visits for welfare checks when father had low mood. Better engagement with With You from both parents in recent months, mother now abstinent, father abstinent from crack, still using cannabis. Police Risk Management Plan in place prior to child's birth. SDAS not aware of MPFT and With You involvement. **Overall: Good with some elements of Requires Improvement around multi-agency working.**

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Child 5 - EWO letter sent, attendance monitored and improved. Mother released from custody before seen by Health and Justice Service. With You didn't identify children in risk assessment as father reported children weren't living with him. Father reported history of cocaine use and issue with alcohol. Father started to disengage due to work commitments and was closed in March 2025. Police reported 6 investigations of domestic abuse including 2 of non-fatal strangulation. Appropriately referred and DARO contacted mother mum. Safer Neighbourhood Officers visited every 2 weeks. The non-fatal strangulation in December 2024 resulted in DARA scoring medium , referral to CSC and arrest of father with the investigation on-going. The initial DARA was scored a high and after review by the DARO scored medium but the rationale for downgrading this is not clear. It was not clear if the case had been referred to MARAC and heard at MARAC. Mother was assessed for group work through SDAS and is on the waiting list. It was felt that given the level of risk she should be having 1:1 work as she may not disclose in a group. The child was not referred to SDAS. There was no domestic abuse alert on Shropshire Community Health NHS Trust records following a notification. **Overall: Good with elements of Requires Improvement**

Child 8 - Known to Education Psychology and EAS. Unannounced visits took place. MPFT reported child on waiting list for 'Space for Conversation', request to expediate. Mother hard to contact, no mobile phone or address on file. She presented with anxiety, PTSD, query ADHD and trauma due to domestic abuse and self-medicated with cocaine. She was signposted to SDAS for Freedom programme and the Financial Wellbeing Team for support. She told staff she was staying with her parents whilst child was on S20. This was not checked with social worker. Fire Service fitted lockable letterbox following deliberate car fire which was drugs related. CSC reported family known since 2017 but only open since 2023. Could have escalated earlier if chronology was used. Child not spoken to in 2022 social work assessment. Over reliance on mother's self-reporting. Mother self- referred to With You around crack and cannabis use, since reported abstinence and discharged. No contact was made with social worker and the service held no information on father. Police reported a 7-year history of domestic abuse, family discussed at PITSTOP. Children were removed because of alcohol use not domestic abuse, but father has history of domestic abuse. School reported changes in social worker and inconsistent support for family. **Overall: Good**

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Child 6 – Mother received medication, psychology support and nursery nurse support with routines from the perinatal mental health team. However, the role of father was not evident in records. West Mids. Ambulance made a safeguarding referral for the child following a road traffic collision where mother was driving under the influence of alcohol and the child was in the car. The child was taken into Police Protection. Mother referred herself to With You, she was not honest about her alcohol use but engaged more after the road traffic collision and is now abstinent. She stated she was a single parent. With You should have had closer links with social worker and exercised professional curiosity to ask about father. Police reported domestic abuse incidents including a non-fatal strangulation, appropriate referrals were made, including to MARAC. MPFT and With You had no knowledge of domestic abuse incidents. MPFT also had no record of the case being heard at MARAC but have a representative at MARAC meetings. Mother attended the Freedom programme through SDAS, this was online at her request. **Overall: Good with elements of Requires Improvement due to lack of information sharing**

Child 7 – Mother previously referred to With You and disengaged. No COMPASS check was made. She re-referred, engaged and is now abstinent. Father failed previous assessments; engagement was poor. Now well engaged and moving to post treatment. Risk assessment was in place but no risk management plan. Child contacted Police as couldn't get into house in early hours. No police deployment and EDT couldn't assist. The child has been discussed at CSE Triage. There was good engagement with school nurse around vaping and cannabis use and the child was seen alone twice. Child was also seen alone by the LAC Nursing Team. Social Care reported that they moved swiftly to safeguard the children when they were left alone and mother was drunk. There was an over-optimism of parents' ability to safeguard when they came off the CP Plan. Parents didn't engage with CIN and social workers took parents word they were abstinent when they had been drinking all along. Children said nothing got better they just stopped telling everyone. Within 4 weeks of ending CP Plan escalated to PLO. GP flagged CSE risk in records. All children known to RJAH. Professional curiosity not exercised at first appointment when it was reported they had an allocated social worker. Child was at risk of permanent exclusion due to escalating behaviours, returned to mainstream and moved to TMBSS to prevent permanent exclusion. **Overall : Good**

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Child 9 – Mother known to MPFT Community Services, Talking Therapies, where they queried her motivation to change. Felt this was not the right service and she needs more specialist counselling. She was signposted to domestic abuse services. CSC reported mother arrested for threats to kill child and child then on S20. There was a positive assessment of mother to return the child to her care but she had not been honest and had resumed the relationship with the perpetrator so now planning for adoption. Queried if mother had capacity to consent to S20 given threats to kill and her mental health. She hadn't taken up offer of housing and had nowhere to live so resumed the relationship. Questioned if she returned due to coercive control. SDAS reported mother is attending Power to Change group. Police reported 4 domestic abuse incidents and father having warning markers for drugs, alcohol and self-harm. One of the DARAs stated there were no children, but this was picked up and the appropriate referral made. **Overall: Good, but some learning.**

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Child 10 - CSC reported opportunities to escalate earlier. The child went from CP to CIN and 5 months later was back on CP Plan then escalated to LPM. Home conditions were poor, mother had mental health needs and was misusing substances. Parents had split and mother isolated. Child was in mother's care. Father supported mother to improve her mental health and home conditions. On reflection relationship support could have been offered sooner as father was seen as key in relation to mother's mental health. Police received a report of the child being left alone whilst mother was drinking and taking drugs. Child Risk Management Plans were in place, DASH completed in relation to domestic abuse incidents and referrals made to CSC. Father has 52 Police records so not seen by Police as a protective factor. CSC reported there was a positive parenting assessment signed off by the Court. SCHT reported Family Nurse Partnership involvement, the health Visitor carried out home visits and the child was open to SALT. The child was not brought to an outpatient appointment at SaTH and another appointment was made. **Overall: Good, with some learning**

Good Practice

- Good use of announced and unannounced visits by both MPFT and EAS
- Good single-agency working to support parents
- Some parents working with With You were able to abstain from substances
- Good continuity of care in one case with only 2 MPFT Care Co-ordinators for father
- Agencies were able to identify single and multi-agency learning

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Learning identified

- MARAC – All agencies can refer to MARAC. Risk assessments referral form available online.
- Rationale for down-grading of DARAs by the DARO is not clearly recorded.
- MPFT Perinatal Mental Health Services clinical supervision forms are being amended to ask direct question about the men in a child's life.
- Too much reliance on parental self-reporting and information is not triangulated. Having all agencies represented at PITSTOP may alleviate this.
- How do we support women who have no choice but to go back to a relationship due to coercive control?
- How are people informed and supported to access the Domestic Violence Disclosure Scheme, also known as Clare's Law?
- Conversations need to take place with parents who are perpetrators about their responsibility to safeguard the child so not all the responsibility is placed on the victim.
- Chronologies are not used effectively to inform decision-making.
- There is not a clear pathway for EWO's to follow when a child becomes Looked After
- PITSTOP to look into MPFT involvement in meetings and consider if their attendance is required if not already in place.
- PITSTOP outcomes are not always recorded on agency records.
- Escalation is not always timely.

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