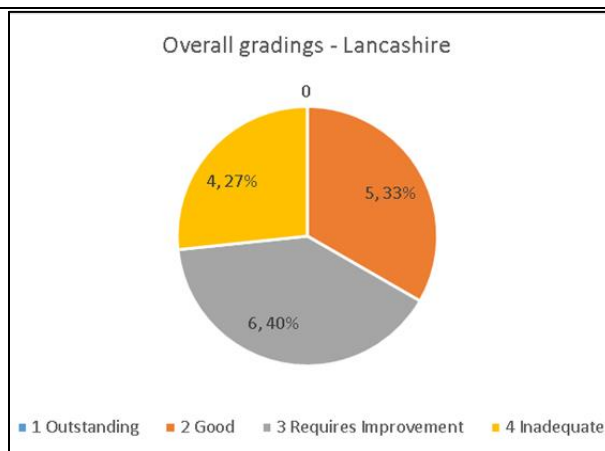
Lancashire Safeguarding Children's Board
Multi-agency Audit 4 Summary Report
Non-Accidental Injuries

Lancashire Safeguarding Boards

Introduction and Background - The topic of Non-Accidental Injuries (NAI) was chosen for Lancashire Safeguarding Children Boards (LSCB) fourth multi-agency audit in order to fulfil a recommendation for the "Child LE" Serious Case Review (SCR), which was published by the LSCB June 2017; a copy of the learning brief associated with this SCR can be accessed via the LSCB website. The recommendation from the Serious Case Review requires the LSCB to "review practice and policy when non accidental injuries to children are suspected or confirmed…in order to reassure all LSCB partners that their practice and policy is effective".

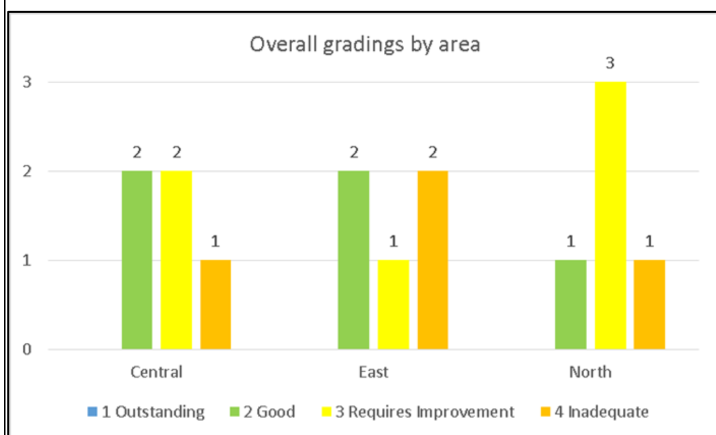
15 cases were chosen for the audit based on the criteria: - "children where physical abuse was suspected/confirmed and who had received a Child Protection medical". All agencies involved with the child/family at the time of NAI were required to complete an audit tool. The audit tool required agencies to analyse the effectives of the work carried out on a single agency basis and grade their involvement accordingly. The multi-agency response to the child's circumstances was considered collaboratively via a multi-agency auditor meeting; these meetings gave the single agency auditors the opportunity to discuss each of the cases from their point of view, highlight any single agency concerns, discuss the extent to which agencies have worked together and address any outstanding areas.

Scoring – Single agencies were asked to rate their involvement with the case by providing an overall grade (in line with CQC and Ofsted grading criteria). The score given was based on the single agency audit returns and was ratified by contributing agencies via the multi-agency audit meetings. The scores give an indication of the execution of current processes with regards to non-accidental injury.



As the graph to the right indicates, 0 of the 15 cases were graded as outstanding. 5 were classed as good, 6 requiring improvement and 4 inadequate.

The second graph (below) illustrates the overall judgement scores by audit area; there was a fairly even split across each of the areas.



Due to the small number of cases audited within each of the areas, the variety of circumstances within each of the case and the fact that the audits will have had contributions from a variety of different agencies (and in some cases different auditors), it is not possible to look for correlations between the areas. Instead, it is more appropriate to concentrate on analysing the key themes and pertinent issues arising from the individual audit returns.

Immediate Action Required - Auditors take responsibility for any single agency actions arising from either the completion of the audit return or as a result of attending the auditor meeting. As a result of the multi-agency auditor meetings a number of immediate actions were highlighted, mainly related to ensuring that information had been shared with all relevant agencies and that the child (and siblings) were currently safeguarded. All immediate actions which were identified have been completed.
Findings
1. Swift response to non-accidental injuries. Children safeguarded promptly and effectively – The audit cases demonstrated that agencies worked together to share information and respond in a timely fashion to ensure that the child was safeguarded with steps taken to mitigate further risk of harm. This finding satisfies the recommendation made in the Child LE SCR.
2. Recording of Child Protection medical information within Children's Social Care records – Inconsistencies were found with regards to how Child Protection medical information is recorded.
3. Misunderstandings with regards to how the Health economy is organised within Lancashire – The audit returns suggest a lack of understanding across agencies with regards to how the health sector is organised within Lancashire. There was confusion regarding who to contact and the extent to which information is shared from one health organisation to another.
4. Information Sharing with GPs – The audits provided evidence of several cases in which information had not been shared with the GP during the investigation process. Details of Child Protection medical can also take several weeks to be shared with partners, this can leave a significant gap in the GP's knowledge of a child's current circumstances. The audit did however acknowledge examples of good practice in some areas of Lancashire with regards to information sharing processes between GPs and Health Visitors; though these were built on local relationships and so were not consistent across the county.
5. Record Keeping – The audit demonstrated the benefits of the CPOMS system to assist schools in collating potential safeguarding concerns, making it easier for school to provide all relevant information should a case escalate and need to be shared with statutory services. There were some areas for potential improvement noted in relation to 'GP coding of potential safeguarding concerns'.
6. Step down process from Children's Social Care to Child and Family Wellbeing service - The audit provided evidence of cases which were not stepped down to the Child and Family Wellbeing service in a timely and effective manner. The LSCB requires assurance that there are effective processes in place for stepping cases down to ensure that they continue to be offered support.
Conclusion - It is pleasing that the NAI Audit provided the board with evidence that agencies are working together to respond to concerns regard the welfare of children with suspected non-accidental injuries. The audit does however identify similar recommendations to those which have been made in previous audits and via serious case review reports; namely in relation to information sharing, record keeping and understanding of health.
Next steps - The findings of the audit have been shared with the LSCB Board. The LSCB quality assurance and performance improvement sub-group have produced an Action Plan which aims to address the findings and recommendations outlined above. This will be monitored by the sub-group and progress reported to the LSCB Board. The sub-group would like to thank all agencies involved in the audits and encourage everyone to consider the themes highlighted by the audit; where appropriate using this report as a tool to aid discussion within teams.