7 Minute Briefing

Child Multi-Agency Audit – Injuries in non-mobile babies

Background

As part of the Walsall Safeguarding Partnership multi-agency audit calendar for 2021-2022 an audit on injuries in non mobile babies took place Jan – Mar 2022 to quality assure that findings from recent Walsall reviews have been implemented. The panel met to analyse the findings on 11th April 2022

Children were known to the following agencies:

Walsall Children's Social Care (CSC)
Walsall Early Help
Walsall Healthcare Trust (Health visiting)
West Midlands Police
Black Country Healthcare Trust
GPs

Aim of the audit

This audit reviewed how effective the multi-agency partnership is in responding to babies or young infants who have experience a non accidental injury by exploring the following questions:

- Do agencies identify and report the risks of physical abuse at the earliest opportunity?
- Is the initial response to physical abuse timely?
- Were policies and procedures followed correctly?
- Was there a strategy meeting? If not, why not?
- Was there a CP medical completed for each incident? If not, why not?

What can you do now?

- Ensure you are contributing to assessments and development of the child's plan
- When a plan comes to an end be sure you know what to expect and what the next steps are for the child and family
- Familiarise yourself with the Walsall Injuries in Babies and Children under 2 years of age guidance
- Book onto the forthcoming learning events throughout June and July:
- Learning from the National Review for Arthur Labinjo-Hughes and Star Hobson
- Understanding the lived experiences of babies, children and young people described as 'non-verbal'
- The Child's Voice at the centre of assessments and plans – Outcome Star training

Case Selection and grade

The sample of cases was randomly selected and comprised of five children who were known to children's social care

Overall, the multi-agency team determined that for four of the audits, the overall evaluation of the practice was 'good', and one audit was evaluated as 'requires improvement'.

There were nuances to these grades, with there being specific issues raised within two of the audits graded as 'good'.

Summary

Overall, these audits found that multi-agency working was effective in the identification and management of the safeguarding concerns identified and that specific decision-making was timely and purposeful. This meant that vulnerable babies and children were safeguarded.

However, there was less focus on the shared multi-agency practice in working with the family that followed.

Areas for Development

- In some circumstances the risks and professional involvement could have been managed differently in order to reduce the impact whilst ensuring that practice remains child-centred and safeguarding the child remains the priority.
- There were delays in getting a second medical opinion for 1 child that led to delays in decision-making. It was not clear how this had been addressed/escalated by other professionals.
- Plans that are developed when professionals are involved in the longer-term with a family generally had a single-agency focus on work undertaken by Children's Social Care.
- There is a challenge in multi-agency practice where medical professionals are only able to provide a professional opinion based on the evidence in front of them, and this is often not likely to be conclusive, similarly none medical professionals required some clarity about what the medical evidence tells in order to make informed decisions

Good Practice

- There was evidence of effective multi-agency working between the Police, Children's Social Care and health, and this led to children being safeguarded.
- The initial triage of information within the Multi-Agency Safeguarding Hub is effective between partners. Information sharing was generally effective and no significant concerns were identified.
- Strategy Meetings are timely with appropriate representation and lead to effective safety planning.
- There were examples of good quality work completed with families in challenging circumstances and where professionals had been able to maintain relationships with parents whilst following up concerns about suspected injuries.
- The Child Protection Medical process is generally working in respect of children being seen when they should, and reports being provided to assist multi-agency decision-making.