Multi-agency Audit on NAI

August 2021

Merton Safeguarding Children Partnership

1. Introduction

The Merton Safeguarding Children Partnership (MSCP, the 'Partnership') undertook a multi-agency audit on Non-Accidental Injury. The topic was chosen to follow on from the thematic scrutiny of our Independent Scrutineer on NAI and sudden unexpected deaths in infants (SUDI), to review strengths and weaknesses in multi-agency practice and share learning across the Partnership.

2. Methodology

Multi-agency partners were asked to complete an audit tool on one case which was identified as involving NAI, which was chosen by Children's Social Care. Due to time limitations, only one case could be identified. Five agencies returned their audit tools (Children's Social Care, Police, CLCH, Kingston Hospital, Epsom and St. Helier's Hospital). All five agencies attended a multi-agency audit workshop session chaired by Children's Social Care, and which was also attended by CCG representatives. Each agency presented their key findings and then, as a group, agencies discussed what worked well and what could have been improved.

3. What worked well?

- **Agencies acted promptly to safeguard children –** there was good inter-agency working, effective communication and information sharing. Agencies were represented at a suitable level of seniority at medical and strategy discussions. This meant that the child, and the child's siblings, were safeguarded, reducing further risk of harm.
- **Collaborative working with the family –** Agencies worked well with the family and with their consent, including involvement of the father. The family's voice is reflected well in case records.
- **Enhanced offer of support to the family –** The family were offered enhanced support based on identification of their needs, irrespective of the Continuum of Need threshold. Health agencies had a plan in place to offer additional support to the family as required.
- **Procedures and protocols were followed, including routine enquiry for domestic abuse.** Kingston Hospital carried out a good assessment and followed procedures regarding routine enquiry for domestic abuse.

4. What could we improve?

- **Rule of optimism -** Agencies questioned whether the rule of optimism led to missed opportunities to safeguard the child and his siblings more promptly.
- **Availability of Senior Managers in Out Of Hours (OOH) -** there was a missed opportunity to safeguard the child and his siblings earlier due to lack of availability of senior managers. There needs to be a clear process in place when a senior manager is not available so that agencies can act swiftly to safeguard children.
- **Although overall information sharing was good, there were some instances where quicker sharing of information would have enabled partners to act more quickly.** Notes from the police interview could have been shared more quickly, and there were some barriers to information sharing of health records considering the family visited two different hospital trusts.

- **Agencies must keep an open mind regarding disguised compliance** – although it was not clear why the family had presented at different hospitals, it was highlighted by agencies that it was important to consider issues of disguised compliance.
- **Agencies noted the importance of assessing and supporting foster carers –** ensuring that foster carers are sufficiently skilled to foster the cohorts of children they are looking after, have regular reviews and are well supported.

5. Conclusions

Overall, agencies concluded that this case provided evidence of good multi-agency working, where agencies acted swiftly to safeguard the children from further harm. Agencies worked collaboratively with the family, who engaged in the support provided. However, it also highlighted some learning about how agencies could have safeguarded the children more promptly through quicker information sharing and availability of sufficiently senior managers to make decisions. It also highlighted the importance of ensuring agencies are open-minded about the prospect of disguised compliance.

6. Next Steps/Recommendations

- Agencies agreed that case management processes were in place and all appropriate action had been taken to ensure the ongoing safety and welfare of the children.
- Multi-agency learning from this case will be shared with the wider partnership