Hull Safeguarding Children Partnership

Line Of Sight- Learning from Child M

Theme- Bruising and Injury to non mobile infant

Published by the Hull Safeguarding Children Partnership (HSCP) business unit

Hull Safeguarding Children Partnership

What is a Line of Sight (LOS)?

The LOS process is a core function of the Hull Safeguarding Children Partnership (HSCP).

The process provides learning opportunities across the partnership to strengthen multi-agency working and focuses on improving outcomes for children and young people.

The process identifies specific learning themes through audit and multi-agency analysis. Learning is implemented across the partnership to improve practice across the safeguarding system

Context of the LOS

- A Line of Sight was held in relation to a non-mobile baby who was observed to have significant bruising.
- Prior to the observed injuries on baby, an Initial Child Protection Conference was held due to professionals believing baby was at risk of significant harm, however, threshold was not agreed for a Child Protection plan, and it was agreed baby would remain open to Social Care under a Child in Need Plan.
- Additional factors identified in the Line of Sight included the risk putative father posed, including the removal of previous children from his care. Other factors included domestic abuse, mother's housing needs, parental alcohol use, and limited support networks from family and friends. Baby also had additional health needs, which required regular intervention with a physiotherapist.

What was the scope?

- The scope of the Line of Sight considered multi-agency involvement to identify learning across the Hull Safeguarding Children Partnership and whether learning from this can help to shape future outcomes for children.
- The review explored whether there were opportunities for earlier intervention and how as a partnership we are working together to respond to the needs of babies.
- Consideration was given to the effectiveness of ensuring babies safety and wellbeing by all agencies involved and whether information was triangulated across all agencies to inform decision making.

Multi agency working and information sharing

Multi Agency Findings

- The review highlighted that information was not shared or triangulated as part the multi-agency planning. Relevant agencies, such as housing and physiotherapist were not part of multi-agency reviews or strategy discussions and therefore did not have knowledge of any concerns or risks. Ensuring a multi-agency approach towards collaborative decision making would have provided greater understanding of family need and appropriate interventions.

- The review identified there is a need to strengthen the understanding of health arrangements across the partnership to ensure that key professionals who have regular ongoing contact with the child are part of the multi-agency discussions/planning, particularly when children have additional health needs.

- Additional findings included domestic abuse incidents in hotels need to be responded to in the same way as residential settings, I.e. investigative enquires such as CCTV speaking to other residents or concerns raised from the hotel need to be shared with CSC.

Current Activity and Developments

- Multi agency Task and Finish group in place to strengthen Strategy Discussion arrangements, with a focus on improvements of timely meetings, correct representation and thresholds applied including planning and sharing of meeting minutes. Workshop/training has been developed for partners.

- Multi agency audit activity undertaken on strategy discussions and shared through OMG and MASA arrangements.

- Development of the Vulnerability Tracker will provide multiagency overview of strategy discussions and PitStop information.

- The Health family structure is regular shared through HSCP newsletters.

- Information sharing guidance included in HSCP threshold document.

- Co-location of IDVAs in perinatal MH team, ILAC, Children with disabilities teams.

- Safeguarding children training delivered to hotel providers.

- Housing have been previously awarded DAHA - Domestic Abuse Housing Alliance Accreditation. Work is currently being undertaken in housing around 'knowing your properties and tenants' and been in properties, who they are and who they are living there with to identify vulnerabilities.

Professional Curiosity

Multi Agency Findings

- Professional curiosity always needs to be exercised when considering potential risk. This includes not being reliant on the information from one parent. This can lead to an over optimism from practitioners which may result in re-referrals. As a partnership, we want to strive for children and families receive the right support and the right time and the right place.

- It is important for practitioners to be professionally curious when considering family need. The review identified that the housing situation could have been explored further due to being placed in temporary accommodation in a hotel and this was not explored within multi agency reviews. Housing colleagues were unaware of potential risks which may have made a difference in terms of accommodation allocation and the statutory homelessness duty.

Current Activity and Developments

- Professional Curiosity 7 point briefing developed across HSCP and HSAB and available on the Collaborative Partnership Website.

- Professional Curiosity Webinar created and open to book across the partnership.

- focus on strengthening understanding of family network through Families First Partnership Programme.

- Right Support, Right Time, Right Place is the revised HSCP Threshold guidance which underpins a ‘whole family approach. Threshold briefings delivered to over 1000+ partners including CSC, Education, Police, Health, VCSE colleagues.

- Practice Management Officers from housing are represented within all HSCP arrangements and subgroups to share updates and inform partners.

Bruising and Injury to non-mobile infants

Multi Agency Findings

- Bruising is the most common injury in children who have been abused. However, it is also a common injury in non-abused children, the exception to this being pre-mobile infants where accidental bruising is rare, 0-1.3% (RCPCH, 2020). This highlights the vulnerability of babies and particularly to those who are unable to independently roll over. Children under 1 was the largest age group for serious incident notifications to National Panel (36%). The 2022 National Panel briefing indicates that for those babies who cannot roll over, conversations should always occur with children's social care for information gathering and a strategy discussion at that point.

Current Activity and Developments

- HSCP guidance and pathway revised on multiagency responses to bruising and injury in non mobile infants.
- Focused theme 'the vulnerability of babies' during Child Safeguarding Week. 6 webinars delivered and recorded with over 230+ practitioners in attendance.
- HSCP The Vulnerability of Babies E-Learning package updated to reflect the revised policy and pathway.
- Workstreams are in place across the partnership to specifically focus on babies which include: F1001D, Safer Sleep, Infant feeding, Injury Prevention.

The role of men, fathers, and non-biological parents

Multi Agency Findings

- It is important for practitioners to be curious about fathers, stepparents, or any other male who play a role in the child's life. Reviews often highlight that fathers are often 'invisible' to services. Whilst it is recognised within research that fathers can act a great source of strength and safety, they can also pose risks to children, which cannot be known if fathers are not included with assessments and interventions. It is important for practitioners to remain curious about the role adults play in children's lives, despite separation or claims of relationship breakdown.

Current Activity and Developments

- SIRS – Sharing information regarding safeguarding – pilot project in Northumberland whereby maternity services were routinely requesting/sharing information with the GP for the dad/partner of the unborn in relation to safeguarding and using this to inform holistic assessments and onward referrals etc. Implemented in that area following learning from a Serious case review as they were then.

- SIRS highlighted as emerging national best practice in The Myth of Invisible Men National Panel report (2020).

- engaging fathers was a themed webinar during Child Safeguarding Week highlighting the vulnerability of babies. 6 webinars delivered on working with male perpetrators, engaging fathers and ICON. Webinars are recorded with over 230+ attended. Feedback included;

"I found this interesting and valuable to recognise that men are important with their children."

"Brilliant reminder for inclusivity"

GOOD PRACTICE IDENTIFIED

Domestic Abuse

Routine enquiry undertaken during antenatal appointments.

information gathering

'knowing your properties and tenants' and been in properties, who they are and who they are living there with to identify vulnerabilities.

Joint planning

Timely joint visit between assessment and locality social worker

Referrals

Information and referral made into a EHASH in a timely manner in order to convene strategy discussion.

Housing

Housing have been previously awarded DAHA - Domestic Abuse Housing Alliance Accreditation