7 Point Briefing – Child M - Theme- Bruising and injury to non-mobile infants

Hull Safeguarding Children Partnership

The Hull Safeguarding Children Partnership have produced this 7 point briefing to share key learning from a Line of Sight. The briefings are intended to be simple so that the reader can absorb the information easily. This can also be used within team meetings as a group-based learning exercise.

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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 multi-agency audit and analysis. Learning is implemented across the partnership to improve practice across the safeguarding system.

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Context of Review

A Line of Sight was held was held in relation to a non- mobile baby who was observed to have significant bruising to their torso, mother was allegedly at that time observed to be extremely intoxicated, putative father also present, despite mother stating they had no contact with one another. The baby was taken to hospital and additional bruising was observed to the side of the head. Both mother and father were arrested.

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 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.

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Good Practice

- Routine enquiry undertaken during antenatal appointments.
- Information and referral made into a EHASH in a timely manner to convene strategy discussion.
- Timely joint visit between assessment and locality social worker.
- Housing teams will need to know their properties and tenants (including those placed in temporary accommodation under a statutory homelessness duty) to be able to meet the Housing regulations. This includes knowing about vulnerabilities which will shape responses tenants and their households needs.
- Housing is currently going through a re-assessment of their Enhanced DAHA (Domestic Abuse Housing Alliance Accreditation) and with that accreditation comes, raising awareness, training, recognition and actions to address domestic abuse.

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Additional Resources and Further Reading

Injury and Bruising to non-mobile Infants
Bruising in non-mobile infants
Training Courses – Learning and Development
Threshold of Needs Guidance – Hull Collaborative Partnership
Information sharing advice for safeguarding practitioners - GOV.UK
Working together to safeguard children 2023: statutory guidance
Child protection service delivery standards - RCPCH Child Protection Portal
What is DAHA Accreditation - daha - Domestic Abuse Housing Alliance
England's Homeless Children: The crisis in temporary accommodation
Tackling infant deaths in temporary accommodation | The Lullaby Trust
professional-curiosity-7-point-guide

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Key Learning

Multi agency working and information sharing
• 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.
Professional curiosity
• 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.
Bruising and injury to non-mobile infants
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.
The role of men, fathers, and non-biological parents
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.

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Next steps: This 7 minute guide will be shared across the partnership enabling learning, discussion, and further reflections.

Working Together conference to be held in January 2025 which will cover learning points in relation to information sharing.

Ongoing national project, SIRS – Sharing information regarding safeguarding – pilot project in 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.

As part of child safeguarding week in 2024, the HSCP hosted several webinars on the vulnerability of babies, these briefings were recorded and available for partners to access here: Child Safeguarding Week – Hull Collaborative

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For further information please visit the Hull Safeguarding Children Partnership website: The Collaborative Partnership – Hull Collaborative Partnership