Line Of Sight Theme:
Bruising and Injuries to non-mobile infants

Hull Safeguarding Children Partnership

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

Who Requested the LOS?

Children's Social Care

Why was the LOS Requested?

A review was requested to explore the multi-agency response to baby and whether this was timely, proportionate, and responsive to their needs. There should be consideration given to the effectiveness of ensuring baby's safety and wellbeing and the co-ordination of responses by all agencies.

What is the context?

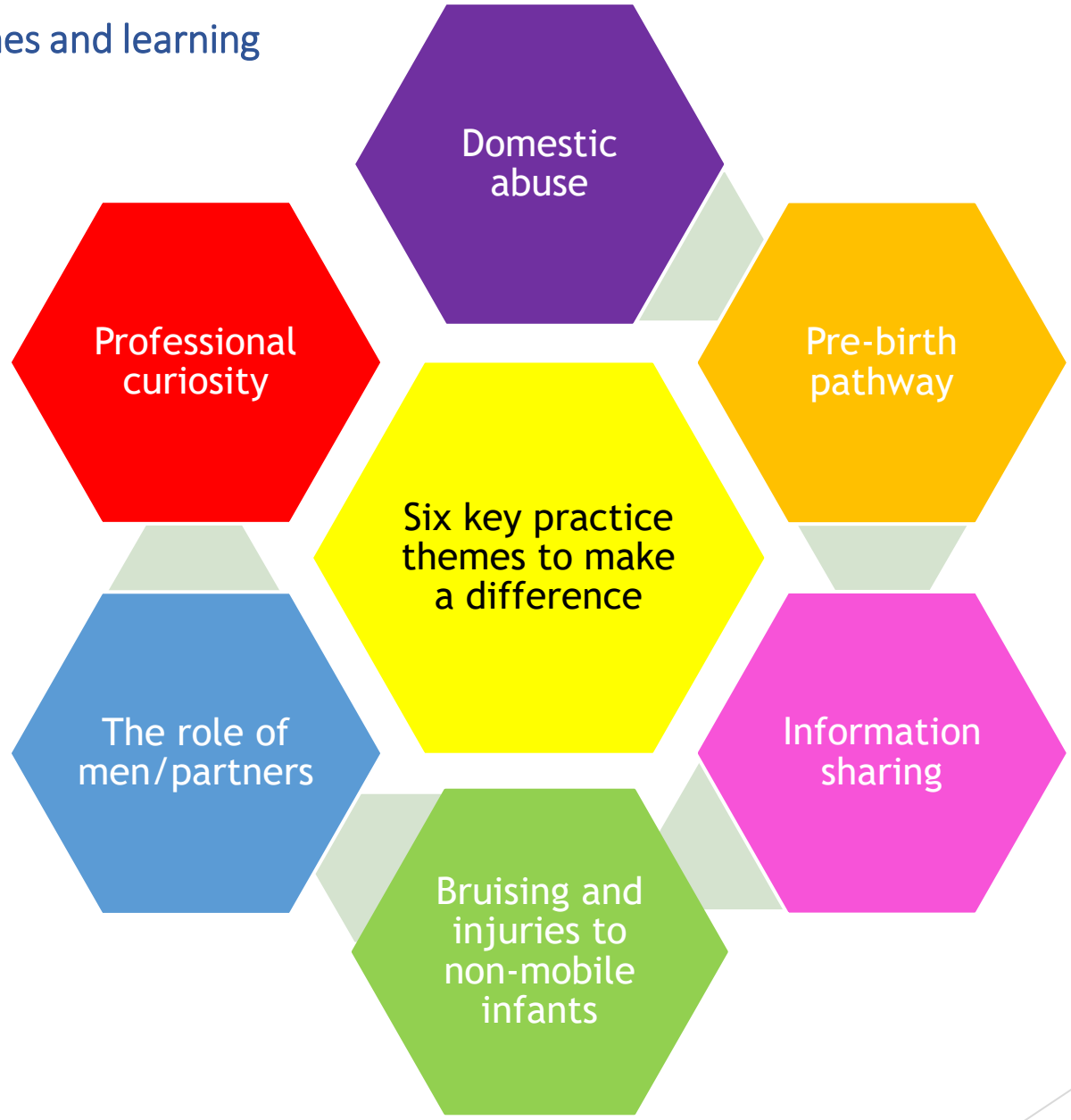
A Line of Sight was held in relation to a young baby who was taken to the Emergency Department (ED) at Hull Royal Infirmary by parents with swelling following immunisations. An x-ray established a broken bone, which resulted in a referral to Children's Social Care (CSC) and a strategy discussion taking place. Further medical examinations were competed which identified that baby had multiple fractures of varying ages. The aging fractures would suggest baby has been seen by other professionals while suffering fractured bones.

Key Lines of Enquiry

- Was there opportunity to identify the risk of harm at an earlier opportunity?
- Is the partnership response robust when identifying bruising and injuries to non- mobile infants?
- Where any concerns during pregnancy highlighted?
- Was intervention offered at the earliest opportunity?

Hull Safeguarding Children Partnership

Key practice themes and learning



Key Practice Themes and Learning

Bruising and injuries to non-mobile infants

- Recommendations from the National Panel briefing paper (2022) states that particular attention should be given to non-mobile infants who are unable to roll over where bruising and/or injury is observed.
- In all cases of observed injury to a non-mobile infant, an explanation should be sought from the parent or carer, where safe to do so, and the explanation given should be recorded. Practitioners should always consider the possibility of maltreatment and understand the explanation in the context of alerting risks, including infants age and stage of development.
- In circumstances where a non-mobile infant presents with bruising and/or injury, and is unable to independently roll over, a referral should be made to EHASH to convene a strategy discussion safeguard the child.
- Partners should utilise the HSCP bruising and injuries to non-mobile infants' policy and process pathway.

Professional curiosity

- The reviewed highlighted that professional curiosity must be exercised around historic Domestic Abuse (DA) incidents, including those family members who come into contact with or play a role in the child(s) life. Having an understanding or awareness of family history will allow practitioners to remain curious when a child presents with an injury. When an explanation of injury is plausible, it requires further curiosity to consider the possibility of maltreatment. This requires further information gathering including a discussion with Children's Social Care (CSC). Consideration needs to be given to the family and social circumstances, including all those living in the family home and adults and family members who do not live in the family home but participate in the child(s) care.

Information sharing

- Notifications or concerns of non-accidental injury in babies need to go through CSC and the police. It is crucial that were these concerns are identified that the police are notified at the earliest opportunity so evidence can be secured and preserved. No single agency can have a full picture of a child's needs and circumstances…information sharing is essential.

Key Practice Themes and Learning

Pre-birth pathway

- The review highlighted that there is a need to review cases at the pre-birth vulnerability panel, i.e., if there is step down and no consent is obtained or there are presenting challenges with engagement, this should be reviewed at the panel to consider any presenting risks to consider the completion of a pre-birth assessment.

Domestic abuse

- There is need to understand how DA markers are utilised across the partnership, especially when cases are heard at MARAC. Information should be recorded on individual records so this can allow for information to be triangulated and develop a greater understanding of any risks, including ensuring relevant information is recorded within all children's records, including newborn babies.

The role of men/partners

- It is important that all agencies make every effort to fully consider the role of fathers and partners and where possible involve them and gather their views. It is crucial to understand family functioning and consider any strengths and risks.
- 'The involvement of prospective and new fathers in a child's life is important for maximising the life- long wellbeing and outcomes of the child regardless of whether the father is resident or not' (National Service Framework, 2004). It is important that all agencies fully consider the role of fathers even if the parents are not living together and where possible involve them and gather their views. This is inclusive of partners who may not be the biological parent. This allows for a great understanding of family functioning including the consideration of any strengths and risks.

Good Practice Identified

Body cameras were worn by police officers which supported in achieving evidence.

Baby was seen quicky in urgent care and supervision was sought by a junior GP to a senior medial GP for guidance, highlights the importance of the supervision process.

There was a strong transition from the assessment social worker to the locality social worker

Useful Information

- HSCP Injury and Bruising to non-mobile Infants (trixonline.co.uk)
- DfE non statutory information sharing advice for practitioners providing safeguarding services for children, young people,parents and carers (publishing.service.gov.uk)
- https://iconcope.org/
- Overview | Child maltreatment: when to suspect maltreatment in under 18s | Guidance | NICE
- Bruising in non-mobile infants (publishing.service.gov.uk)
- The Myth of Invisible Men (publishing.service.gov.uk)
- unborn-pre-birth-pathway.pdf (trixonline.co.uk)
- **Bruising in non-mobile infants (publishing.service.gov.uk)**
- Training courses – Hull Collaborative Partnership
- Home – Family Hubs (familyhubshull.org.uk)

1. Background and Concerns

A Line of Sight was held in relation to a young baby who was taken to the Emergency Department (ED) at Hull Royal Infirmary by parents with swelling. An x-ray established a broken bone, which resulted in a referral to Children's Social Care (CSC) and a strategy discussion taking place. Further medical examinations were competed which identified that baby had multiple fractures of varying ages. The aging fractures would suggest baby has been seen by other professionals while suffering fractured bones.

2. Purpose of the Review?

A review was requested to explore the multi-agency response to baby and whether this was timely, proportionate, and responsive to their needs. There should be consideration given to the effectiveness of ensuring baby's safety and wellbeing and the co-ordination of responses by all agencies.

3. Key Lines of Enquiry

- Was there opportunity to identify the risk of harm at an earlier opportunity?
- Is the partnership response robust when identifying bruising and injuries to non- mobile infants?
- Where any concerns during pregnancy highlighted?
- Was intervention offered at the earliest opportunity?

7. Further information – links

- HSCP Injury and Bruising to non-mobile Infants (trixonline.co.uk)
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6. Next Steps

- The HSCP Injury and bruising to non-mobile infants' policy and procedure will involve a learning launch across the partnership.
- The HSCP pre-birth pathway policy has been developed and webinars across the partnership have delivered.
- The HSCP will be involve in partnership task and finish groups around the importance of engaging men, fathers and partners.
- ICON training will be revised and offered across the partnership.
- This 7-minute guide will be shared across the partnership to compliment discussions, training, and learning.
- Training to support practitioners with key learning points is available through the HSCP Learning Programme 2024/25 and attached links (detailed above).
- All key safeguarding agencies to share learning across their own organisation.

5. Good Practice

- Body cameras was worn by police officers which supported in achieving evidence.
- Baby was seen quicky in urgent care and supervision was sought by a junior GP to a senior medial GP for guidance, highlights the importance of the supervision process.
- Strong transition from the assessment social worker to the locality social worker

4. Key Learning

Bruising and injuries to non-mobile babies – Recommendations from the National Panel briefing paper (2022) states that particular attention should be given to those children who are unable to roll over where bruising and/or injury is observed. In all cases of observed injury to a non-mobile infant, an explanation should be sought from the parent or carer where safe to do so, and the explanation given should be recorded. Practitioners should always consider the possibility of maltreatment and understand the explanation in the context of alerting risks, including infants age and stage of development. In circumstances where a non-mobile infant presents with bruising and/or injury, and is unable to independently roll over, a referral should be made to EHASH to convene a strategy discussion safeguard the child. Partners should utilise the HSCP bruising and injuries to non-mobile infants' policy and understand the process pathway.

Professional curiosity- The reviewed highlighted that professional curiosity must be exercised around historic Domestic Abuse (DA) incidents, including those family members who come into contact with or play a role in the child(s) life. Having an understanding or awareness of family history will allow practitioners to remain curious when a child presents with an injury. When an explanation of injury is plausible, it requires further curiosity to consider the possibility of maltreatment. This requires further information gathering including a discussion with Children's Social Care (CSC). Consideration needs to be given to the family and social circumstances, including all those living in the family home and adults and family members who do not live in the family home but participate in the child(s) care.

Domestic Abuse - There is need to understand how DA markers are utilised across the partnership, especially when cases are heard at MARAC. Information should be recorded on individual records so this can allow for information to be triangulated and develop a greater understanding of any risks, including ensuring relevant information is recorded within all children's records, including newborn babies.

The role of partners- It is important that all agencies make every effort to fully consider the role of fathers and partners and where possible involve them and gather their views. It is crucial to understand family functioning and consider any strengths and risks.

Pre- Birth Pathway – The review highlighted that there is a need to review cases at the pre-birth vulnerability panel, i.e., if there is step down and no consent is obtained or there are presenting challenges with engagement, this should be reviewed at the panel to consider any presenting risks to consider the completion of a pre-birth assessment.

Information Sharing- Notifications or concerns of non-accidental injury in babies need to go through CSC and the police. It is crucial that were these concerns are identified that the police are notified at the earliest opportunity so evidence can be secured and preserved. No single agency can have a full picture of a child's needs and circumstances…information sharing is essential.