Local Child Safeguarding Practice Review
Babies with injuries
Practice Brief

23/1/22. Developed by SSP BSU. With thanks to information and materials developed by Jade Batten, Natalie Herring, Yasmin Gordon, Dr Claire Broomfield, Kate Clements, Joanne Smith and Fiona Francis.
Vulnerability under 1's webinar.

How to use this document

The aim of this document is to raise awareness of the learning themes identified during a recent Local Child Safeguarding Practice Review (LSCPR) and provides some general information and definitions and signposting to additional resources. Where relevant there will be links/references to national reviews and audits.

Please share this resource widely and reflect on how this impacts on your practice.

This is a large document and you can look at it as a whole or dip in and out at your convenience.

There are also hyperlinks to external resources such as websites which can be accessed by either ctrl+click on the image/icon or hyperlink. Alternatively you can use your mouse to right click and select open link from the options. If you are unable to open a hyperlink please copy the information and paste into your usual internet search engine e.g. Google or Bing.

Themes identified during this review

The review was undertaken to consider systems and practice within and between partner agencies in Swindon, specifically with regard to the assessment and safeguarding of infants prior to and following a non-accidental injury (in each case the babies suffered fractures).

This review reflected on the learning identified in recent rapid reviews. The themes and learning identified are précised below, together with learning identified in national reviews. The themes will be covered in more detail on subsequent slides and signposting to additional learning resources.

- Suspected injuries to mobile and non-mobile babies
- Brief Unresolved Unexplained Events (BRUE)
- Working with Fathers
- Professional curiosity
- Information sharing
- Parental mental health
- Impact of COVID-19

Additionally this document will signpost to the following relevant procedures and guidance documents for professionals working in Swindon.

- SSP Multi-Agency Child Protection Standards
- SSP Unborn Baby Protocol

To access the report click here.

Title: **Safeguarding Unborn Babies**

Swindon Safeguarding Partnership

Background

Pregnancy is an exciting time in a parents life however, it can also be a time of great stress and anxiety which can impact on the safeguarding of unborn babies. Pregnancy is a critical window of opportunity where parents are most receptive to offers of advice and support (1001 Critical Days, 2015)

1 Unborn Baby Protocol

The Unborn Baby Protocol provides all professionals with advice and guidance regarding the safeguarding risks to unborn babies in conjunction with the Right Help at the Right Time document. The protocol also assists professionals in their decision making around referrals children's social care.

2 Vulnerabilities of Unborn Babies

Vulnerabilities that can increase the risk to unborn babies include unwanted/concealed pregnancy, domestic abuse, substance misuse and Mental Health Illness. However, this is not an exhaustive list and consideration must be given to each individual baby and in consideration with the guidance in the Unborn Baby Policy. **Remember,** 'multiple matters' – Increased vulnerabilities increases the risk.

3 Antenatal Assessment

Antenatal assessment is a valuable opportunity to develop a multi-agency approach to supporting families where there are vulnerabilities or risk of potential harm to the unborn baby. The antenatal period provides a key opportunity to implement interventions, explore parents ability to protect their unborn baby and ensure there are clear plans in place for discharge from maternity care following babies birth.

4 Timeliness of Intervention

Early assessment, intervention and support in the antenatal period can help to minimise any potential harm and give maximum time for interventions to take place. All professionals working with the family are responsible for ensuring the timeliness of intervention.
If a mother books late into her pregnancy this should be considered when planning interventions and when Children's Social Care are undertaking a Pre Birth Assessment

5 Information Sharing

Research and audits consistently show the importance of early information sharing to ensure effective integrated working and is a crucial element of early intervention and safeguarding. Practitioners should be proactive in sharing information as early as possible to help identify, assess and respond to risk or concerns about the safety and welfare of unborn babies. GDPR does **not** prevent or limit the sharing of information for the purpose of keeping children safe. The SSP have developed a practice briefing on information sharing which you can access here

6 Involvement of Fathers

An unborn babies father must be given the same level of consideration as the mother. Recent Serious Case Reviews in Swindon have highlighted a lack of information that is known about fathers. Involving fathers early on in pregnancy supports lifelong wellbeing and outcomes for the child, regardless of residency. Every effort should be made to include information on the unborn father or partner if not the biological father to the unborn baby.

7

Access the SSP: Safeguarding unborn babies - 7-minute brief - Swindon Safeguarding Partnership
Access SSP Practice Brief: Effective information sharing and consent - Swindon Safeguarding Partnership

Suspected injuries to mobile and non-mobile babies

Suspected Bruising on Children

Background

Bruising is the most common presenting feature of physical abuse in children. The Triennial analysis of Serious Case Reviews (SCR's) identified that those under the age of 1 year are consistently over presented in SCR's as a result of a severe injury or death as a result of physical abuse (Sidebotham et al, 2016).

This short clip (from Nottinghamshire Council) describes the action a practitioner should take if they become aware of a bruise/suspicious mark on a non-mobile baby.

Swindon Safeguarding Partnership

What to do when you suspect a Non Accidental injury or bruise

If the child has been seriously injured call 999 immediately

Refer to MASH who will convene a strategy discussion.

Provide parent/carer with Bruising in non mobile babies leaflet

Do not ask the parents to attend hospital or GP at this stage

If the child is already open to Children's Social Care contact the allocated social worker or their manager.

Why it matters

Recent Rapid Reviews in Swindon have highlighted a lack of awareness of the Suspected Bruising or Unexplained Injury in a child who is not independently mobile policy. The younger the child, the greater the risk that bruising is non accidental and therefore there is a greater potential risk. Infants under the age of 1 are more at risk of being killed by another person, usually a carer, more than any other age group of children.

Sentinel injuries

A sentinel injury is a 'minor' injury often seen in non mobile children and is recognised as a precursor to a more significant injury.

A systematic review by the Royal College of Paediatric Health (2020) identified a bruise was the most frequent sentinel injury.

What to look for

Bruises away from bony prominences

Bruises to soft areas such as face, abdomen, arms, buttocks, ears and hands

Multiple or clustered bruising

Imprinting or Petechiae (small red or purple spots caused by bleeding into the skin)

Symmetrical Bruising

Questions to ask

Have carers been asked for an explanation? Record the explanation.

Do not suggest how it may have occurred

When was the bruising first noticed?

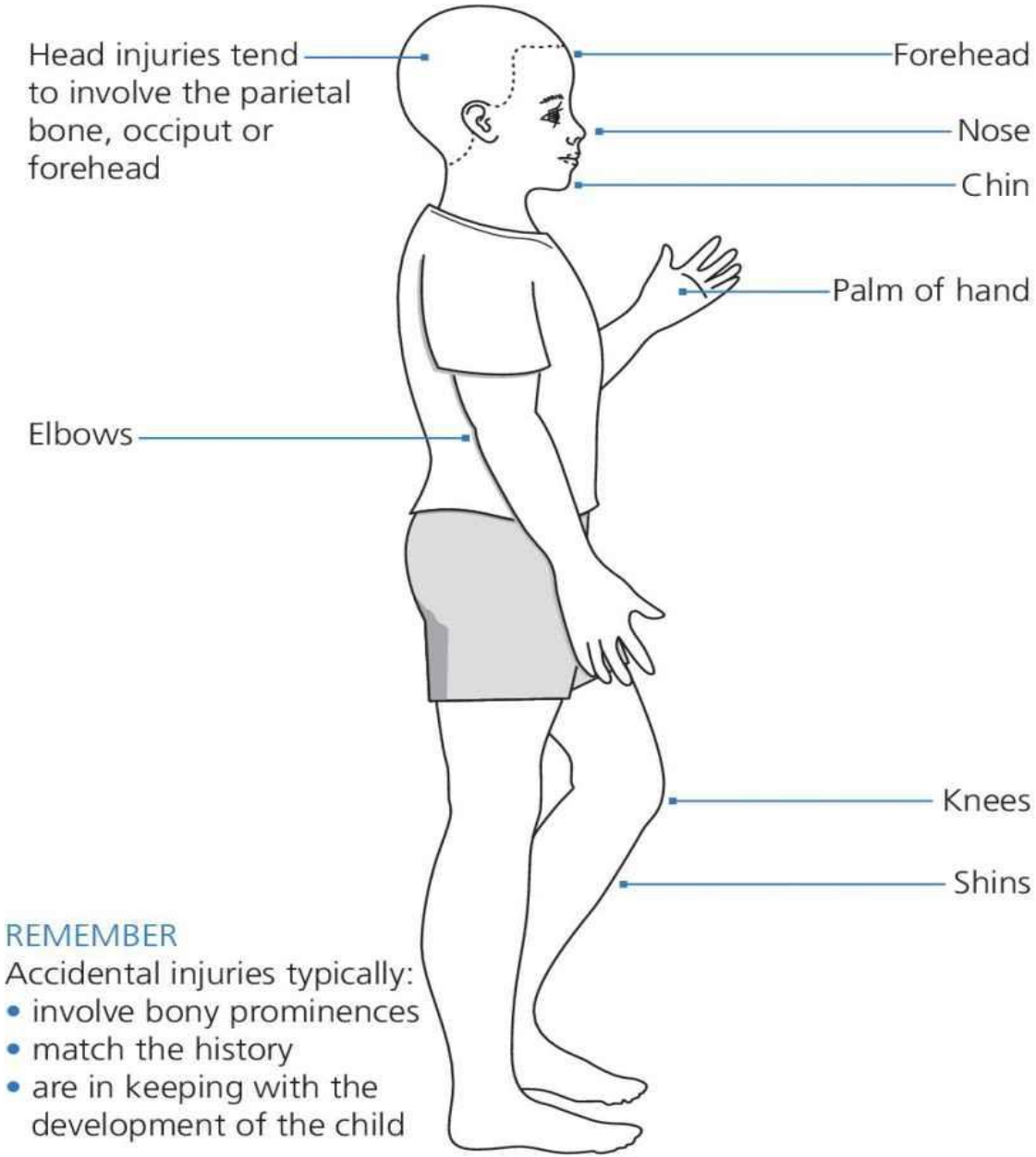
Is the injury consistent with child's developmental stage?

It is also important to document the injury on a body map

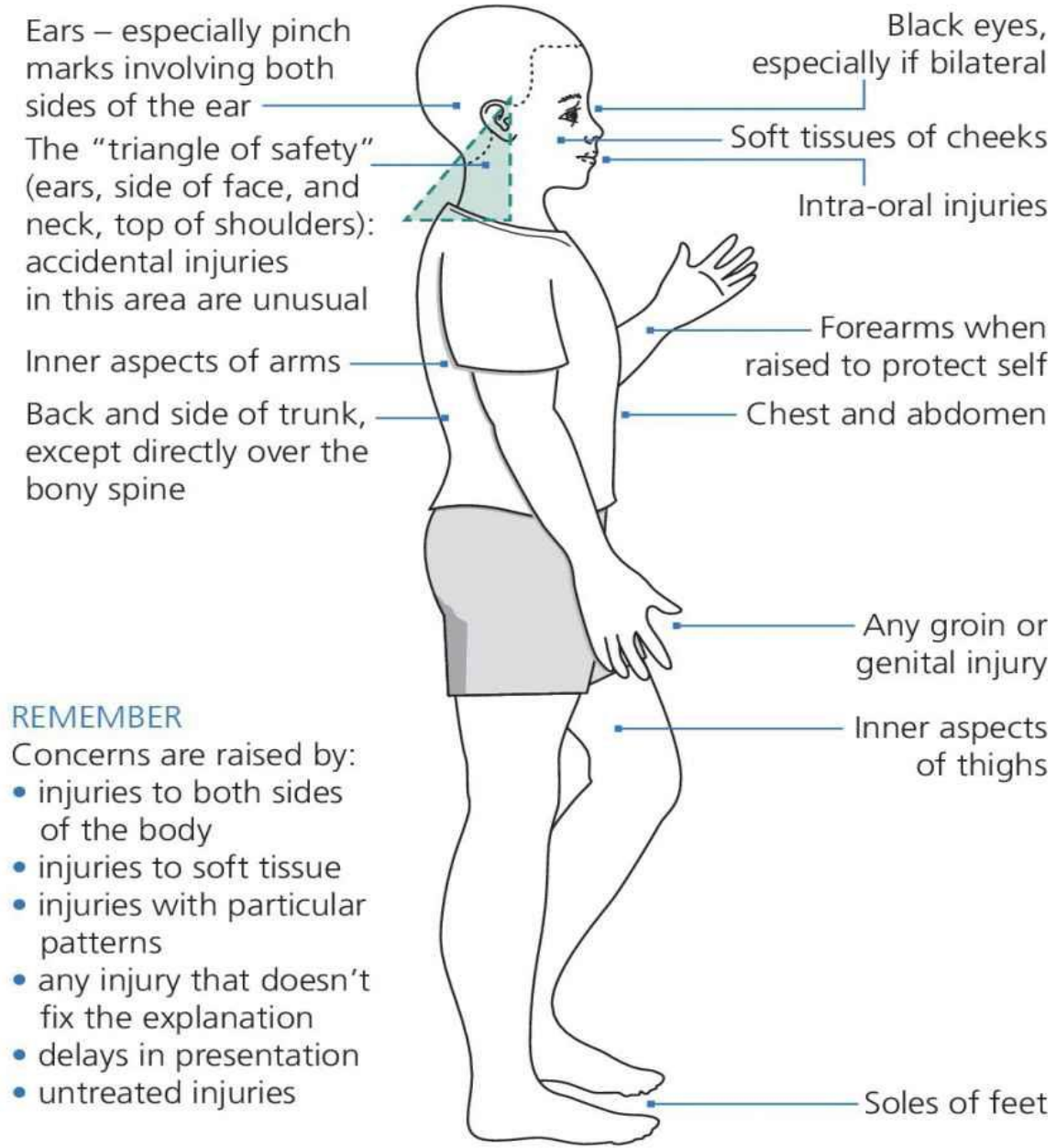
Use of professional judgement

Professional judgement is based on your role, training and experience. However, it is important to recognise that non accidental injuries often occur on the same areas as accidental ones.

It is vital that a professional demonstrates professional curiosity when seeking explanations, this is especially important if the professional feels as though they know the family well.

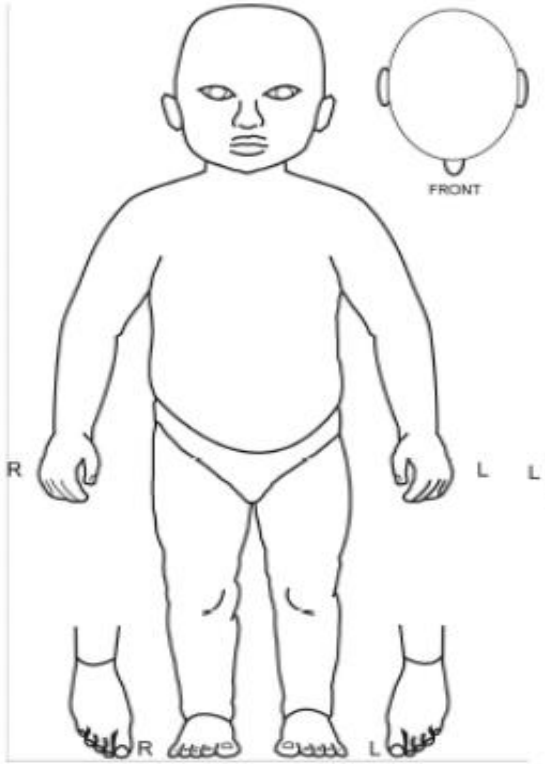


(a) Typical accidental injuries



(b) Typical abusive injuries

Body Map



Child's name:		
Date of birth:		
Date/time of skin markings/injuries observed:		
Who injuries observed by:		
Information recorded:	**Date:**	**Time:**
Name:		**Signature:**

Resources: Bruising in Non-Mobile Infants

- ✓ Swindon policy "Suspected Bruising or Unexplained Injury in a child who is not independently mobile" however, it does also include **bruising and marks on children of any age.**

- ✓ The policy includes a clear, multiagency pathway at the back of the document for professionals to follow if they are unsure of what to do.

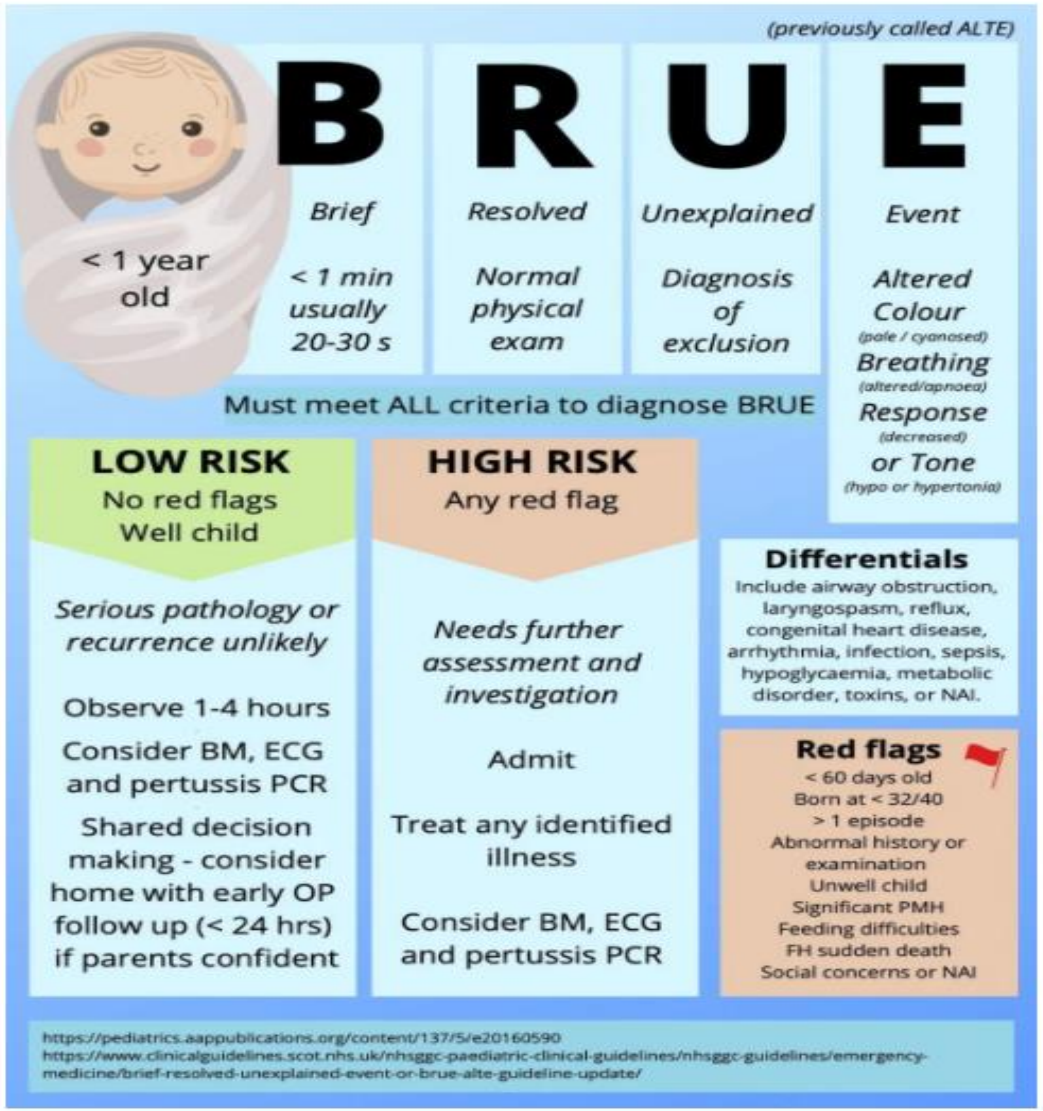
- ✓ The SSP practice brief includes additional guidance on the developmental ages of children and gives examples of posture and large movements, social behaviour and play, vision and fine movements, hearing and speech. To access this brief click here.

- ✓ SSP Information leaflet for parents/carers

- ✓ See also NSPCC leaflet – bruises on children.

Brief Resolved Unexplained Event (BRUE)

What is a Brief Resolved Unexplained Event (BRUE)?



- A BRUE is when an infant younger than one year stops breathing, has a change in muscle tone, turns pale or blue in colour, or is unresponsive.
- The event occurs suddenly, lasts less than 30 to 60 seconds, and is frightening to the person caring for the infant.
- BRUE is present only when there is no explanation for the event after a thorough history and exam.
- An older name used for these types of events is an apparent life-threatening event (ALTE).

Source: [Brief resolved unexplained event - BRUE: MedlinePlus Medical Encyclopedia]

The main differences between the definitions of ALTE and BRUE

	BRUE	ALTE
Age	Age limit <1yr old	No particular age limit
Airway	Not included	Choking and gagging
Breathing (Pattern)	Absent breathing, diminished breathing, and other irregularities	Apnoea (Central or occasionally obstructive)
Circulation (Colour)	Cyanotic/Pale	Cyanotic/Pallid/ Erythematous/Plethoric
Disability (Tone/ Consciousness)	Marked change in tone, including hypertonia or hypotonia	Any change in muscle tone
	Altered level of responsiveness (May indicate serious cardiac, respiratory, metabolic, or neurologic event)	Not specified
Causes	Only if there are no other causes	Might have included such as GORD/LRTI/Meningitis/Sepsis

Source: Something BRUE-ing? – PaediatricFOAM

History is key!

BEFORE

- Location and position if infant
- Awake/Sleep?
- Related to feeding?
- Anything nearby to compromise airway?
- Recent History:
  - Recent illness/fever
  - Feeding volumes
  - Wet/dirty nappies?
  - Any recent injuries?

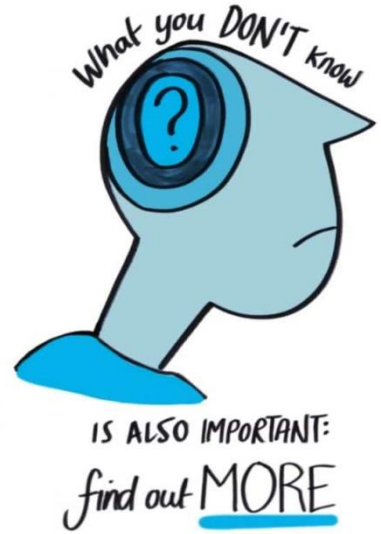
DURING

- Choking/Gagging?
- Child active, floppy or stiff?
- Any repetitive movements observed – seizure?
- Breathing pattern
- What was skin colour?

END Of EVENT

- Duration
- How did it stop?
- What did caregiver do?
- When/how was medical help obtained?
- Are they back to normal self?

Be Professionally Curious



- ✓Consider the Family/Social Factors
- ✓Supervision around the event
- ✓What do you know about the family?
  - ✓Known to Childrens Social Care?
  - ✓Mental health/substance misuse?
  - ✓Frequent attendances child/siblings?
  - ✓Recent stresses?
  - ✓Risk factors for infant (ACES, Domestic Abuse/violence, socioeconomic)
  - ✓Was there a delay in presentation to healthcare?

See SSP Practice Brief – Professional Curiosity for further guidance.

Think Safeguarding!

Resources: BRUE

Further information about BRUE can be found on the following websites:

- ✓ Brief resolved unexplained event - BRUE: MedlinePlus Medical Encyclopedia (2020) includes information relating to causes/symptoms.
- ✓ Brief Resolved Unexplained Event (BRUE) (nationwidechildrens.org) includes information relating to causes/symptoms.
- ✓ Something BRUE-ing? – PaediatricFOAM
- ✓ NHSGGC - Brief Resolved Unexplained Event or BRUE (ALTE guideline update) (scot.nhs.uk)
- ✓ Clinical Practice Guidelines : Brief Resolved Unexplained Event BRUE (rch.org.au)
- ✓ https://www.nationwidechildrens.org/family-resources-education/health-wellness-and-safety-resources/helping-hands/brief-resolved-unexplained-event-brue
- ✓ Approach to Brief Resolved Unexplained Events (BRUE)" by Jonathan Fried and Beth Harper – You Tube (2020, 11 minutes) https://www.youtube.com/watch?v=Gkzh0I1bL70
- ✓ For parents/carers – American Academy of Pediatrics (2021) Brief Resolved Unexplained Event | Pediatric Patient Education | American Academy of Pediatrics (aap.org)

Swindon Safeguarding Partnership

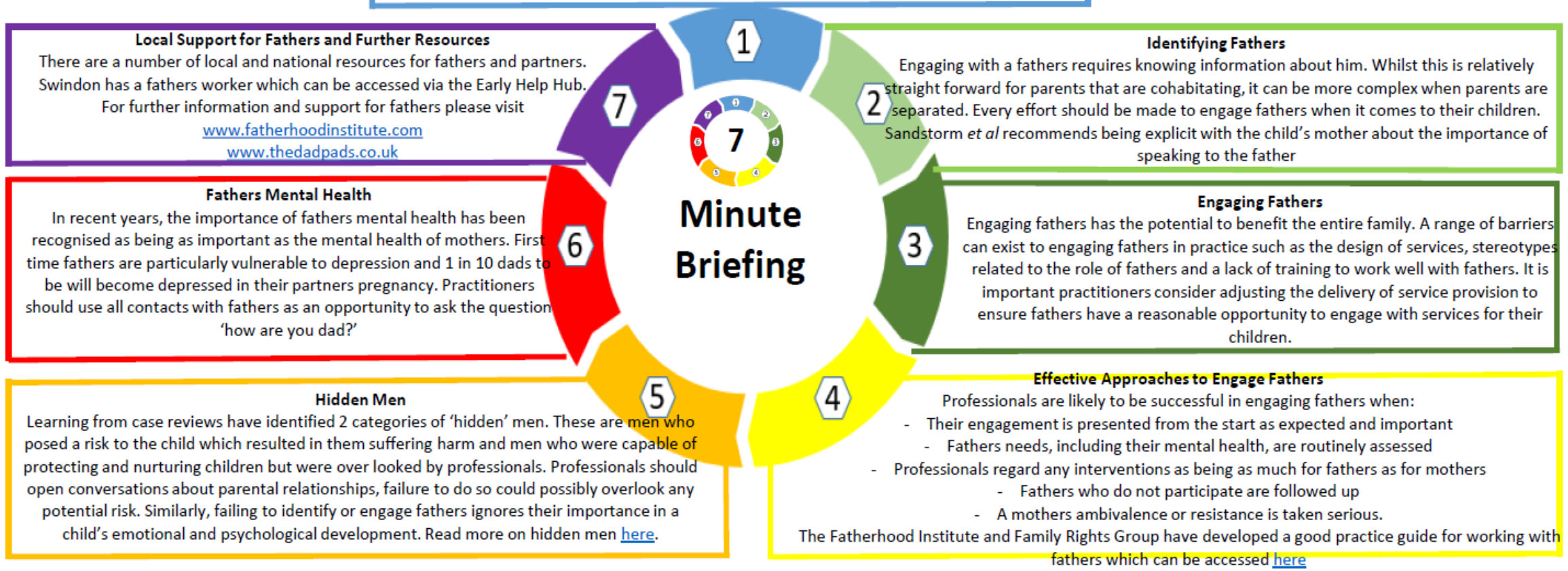
Working with Fathers

Title: Working with Fathers

Swindon Safeguarding Partnership

Background

Gaps in working with fathers have been identified at both a local and national level. The Triennial Analysis for Serious Case Reviews (2014-2017) highlights a failure to identify significant figures within families. Men in particular are often invisible or absent in assessments by professionals and as a result, very little information was known about them.



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Identifying Fathers

Engaging with a fathers requires knowing information about him. Whilst this is relatively straight forward for parents that are cohabitating, it can be more complex when parents are separated. Every effort should be made to engage fathers when it comes to their children. Sandstorm *et al* recommends being explicit with the child's mother about the importance of speaking to the father

2

3

Engaging Fathers

Engaging fathers has the potential to benefit the entire family. A range of barriers can exist to engaging fathers in practice such as the design of services, stereotypes related to the role of fathers and a lack of training to work well with fathers. It is important practitioners consider adjusting the delivery of service provision to ensure fathers have a reasonable opportunity to engage with services for their children.

4

Effective Approaches to Engage Fathers

Professionals are likely to be successful in engaging fathers when:

- Their engagement is presented from the start as expected and important
- Fathers needs, including their mental health, are routinely assessed
- Professionals regard any interventions as being as much for fathers as for mothers
- Fathers who do not participate are followed up
- A mothers ambivalence or resistance is taken serious.

The Fatherhood Institute and Family Rights Group have developed a good practice guide for working with fathers which can be accessed here

5

Hidden Men

Learning from case reviews have identified 2 categories of 'hidden' men. These are men who posed a risk to the child which resulted in them suffering harm and men who were capable of protecting and nurturing children but were over looked by professionals. Professionals should open conversations about parental relationships, failure to do so could possibly overlook any potential risk. Similarly, failing to identify or engage fathers ignores their importance in a child's emotional and psychological development. Read more on hidden men here.

6

Fathers Mental Health

In recent years, the importance of fathers mental health has been recognised as being as important as the mental health of mothers. First time fathers are particularly vulnerable to depression and 1 in 10 dads to be will become depressed in their partners pregnancy. Practitioners should use all contacts with fathers as an opportunity to ask the question 'how are you dad?'

7

Local Support for Fathers and Further Resources

There are a number of local and national resources for fathers and partners. Swindon has a fathers worker which can be accessed via the Early Help Hub. For further information and support for fathers please visit

www.fatherhoodinstitute.com

www.thedadpads.co.uk

The hyperlinks in the 7 minute brief above have been included in the resources slide at the end of this section. Please refer to that slide if you wish to access that information.

Fathers Matter

It's well-established that fathers matter. Society is changing in how we view fathers and their roles.
It is no coincidence that higher father involvement is linked with lower parenting stress and depression in mothers.

Changes in UK law, for example, parental responsibility for fathers named on their children's birth certificates whether married or not.
The contribution that fathers can make to the lives of children and families is substantial.

Studies repeatedly show that child protection work tends to focus on mothers, with fathers having a peripheral presence in case files, child protection conferences and home visits.
This has given rise to a series of descriptions of fathers as 'invisible', 'ghosts' or 'shadows'.

Continued…

The early years:
Evidence tells us that young children who fathers are actively involved and have a positive and sensitive experience from their father have better school readiness, higher educational achievement and reduced risk of suspension and expulsion. Absent fatherhood has been shown to negatively affect children, for example, by contributing to difficulties with peer relationships including bullying.

The teenage years:
Early childhood play with a father contributes to teenagers' sense of self-worth. Teenagers who feel they matter to their father or stepfather typically have significantly better mental health. Poor relationships with fathers affects teenagers significantly and this means that a 'whole family' to any adolescent problems is essential, rather than a sole focus on the mother.

NSPCC research ‘Hidden Men’ (2005)

Analysis of serious case reviews, two categories of ‘hidden’ men emerged:

- ✓Men who posed a risk to the child which resulted in them suffering harm.
- ✓Men, for example estranged fathers, who were capable of protecting and nurturing the child but were overlooked by professionals.

Source: Hidden men: learning from case reviews | NSPCC Learning

Similar themes were identified in Child Safeguarding Practice Review Panel Review (CSPR) **The Myth of Invisible Men (2021).** See next slides for further information.

The Myth of Invisible Men
Child Safeguarding Practice Review Panel Review (2021)

Context: 35% of all serious incident notifications to the CSPR involve serious harm to babies, the vast majority involve physical injury or death. This is the biggest category of all notifications that the Panel sees.

In the majority of cases where babies have been injured or killed, men are the perpetrators – research suggests that men are between 2 and 15 times more likely than women to cause this type of harm in under 1s. The greater prevalence of male abusers sits alongside a description of men as too often being 'hidden' or 'invisible' to safeguarding agencies.

This review:
Safeguarding practice with fathers of young children is something of a paradox.

The Myth of Invisible Men' reflects the panel's resolve to get behind this paradox so that work with fathers might become less ambiguous and more effective.

Source: **The Myth of Invisible Men (2021)**

Review Findings:

- ✓Approximately 700,000 men become biological fathers a year.
- ✓These convicted male perpetrators represent 0.001% of fathers.
- ✓Babies are twice as more likely to be killed by their father than their mother.
- ✓Mostly biological father as perpetrator.
- ✓Studies reviewed showed an unclear picture re. evidence of any particular risk factors such as mental health/substance misuse/poverty as key contributing factors.
- ✓However, studies were small and it was highlighted that these issues are often under reported and under recorded in men in comparison to women therefore they maybe under represented in the studies.

Findings continued:

- ✓Lack of systematic attention being given to fathers
- ✓Found no routine engagement with maternity services, health visiting, primary care and early years despite being recognised in guidance and polices
- ✓Lack of information sharing between adults' and children's services
- ✓Professionals relying too much on mothers for essential information
- ✓Professionals not wishing to appear judgmental about parents' personal relationships
- ✓Overlooking the ability of estranged fathers to provide safe care for their children

Overview:

Highlights an urgent need to improve how the system sees, responds to and intervenes with men who may represent a risk to the babies they are caring for.

For this group of men, the role that they play in a child's life, their history of parenting and their own experiences as children and how this effects them as adults, are too frequently overlooked by the services with responsibilities for safeguarding children and for supporting parents.

Some Practice Points

- Make father engagement by universal services routine, systematic and expected in order to support ALL men's caregiving and maximise the chances of “spotting” the ones who are struggling with hope to prevent the harm/death of the child.
- Referrals and information sharing should include information about the father. We should be identifying new male partners in the household and recording their details/ sharing if concerned. Check for aliases, names which are incorrectly spelt.
- Speaking separately to the father rather than gathering information solely through the mother.
- Make sure they are aware of concerns.
- Arranging separate home visits if necessary to explain the relevance of his involvement with the child, communicating a willingness to include him in decisions.
- Fathers can be a positive resource to a family.
- Professional curiosity.
- Better father inclusion in Child Protection practice.

Resources: Working With Fathers

- ✓SSP 7 Minute brief: Working with fathers - 7-minute brief - Swindon Safeguarding Partnership

- ✓Engaging with men in social care: a good practice guide | www.basw.co.uk
- ✓The Fatherhood Institute » The UK's fatherhood think tank

- ✓DadPad | The Essential Guide for New Dads | Support Guide for New Dads (thedadpad.co.uk)

Child Safeguarding Practice Review Panel
Report July 2020

Out of Routine: A review of sudden unexpected death in infancy (SUDI) in families where the children are considered at risk of significant harm

A Review of Sudden Unexpected Death in Infancy (SUDI) in Children at risk of Significant Harm

1. Introduction to National Review. This is the second national review commissioned by the Child Safeguarding Practice Review Panel (the Panel). who oversee all statutory case review activity in England. Infants (under 1) dying suddenly and unexpectedly represent one of the largest groups of cases notified to the Panel, with 40 notifications between June 2018 and August 2019. While these represent only a proportion of all SUDI, they occur in families who are particularly vulnerable. Access the full report here.

2. Methodology. The review examined 14 incidents of SUDI from 12 local areas that were representative of the 40 SUDI cases reported to the Panel between June 2018 and August 2019. There were four parts to the review:
a) fieldwork visits in 12 local areas. b) discussions with key professionals and experts in respect of SUDI. c) a review of the research literature. d) analysis of national child death review data.

3. Key Findings. The review confirmed known risk factors for SUDI such as co-sleeping, non safe sleeping environment, smoking in pregnancy, deprivation and overcrowding. Co-sleeping was a feature in 38 of the 40 cases reviewed. Parental alcohol and drug use were also common, as were issues related to parental mental ill-health. Routines in the families were often chaotic and inconsistent.

4. Key Findings. There needs to be better links between the work in local areas to reduce the risk of SUDI and wider strategies for responding to neglect, deprivation, Domestic Abuse (DA), Parental Mental Health and Substance Misuse concerns.
Professionals should adopt a supportive but flexible and responsive partnership with parents including co-production of information and support.

5. Developing a Practice Model. The findings suggest the need for a 'Prevent and Protect' practice model with 4 key components:
- robust commissioning to promote safe sleeping within a local strategy
- multi-agency action to address pre-disposing risks of SUDI for all families
- differentiated and responsive multi-agency practice
- underpinning systems, processes, tools etc.

6. Recommendations. i) To explore how data from child death reviews can be cross checked with data collected through serious incident notifications to ensure learning is identified and disseminated. **ii)** To ensure the learning from this review can be embedded in the Healthy Child Programme. **iii)** For the Department of Health and Social Care to work with key stakeholders to develop tools and processes for frontline professionals working with families with children at risk to promote safer sleeping.

7. Research Focus. Two areas of further research were also identified:
- To establish the efficacy of different interventions to reduce the risk of SUDI within families whose children are at risk
- To research the use of behavioural insights and models of behaviour change with parents

There is a more detailed brief on the NSPCC website: CASPAR briefing.

Thanks to Wirral Safeguarding Children Partnership

Useful Resources: SUDI in Children at risk of Significant Harm

Safer Sleeping

- Useful information for professionals to raise awareness includes short video clips and posters.
- Walsall Safeguarding Partnership > Children, Parents and Carers > Parents and Carers > Safer Sleeping
- Black Country Child Death Overview Panel (CDOP): 7 Minute Briefing **- Safe Practices for Babies**
- Safer Sleep for baby - Lancashire Safeguarding Children Board
- Safer sleep advice: How to reduce the risk of SIDS for your baby - The Lullaby Trust

There are a range of useful resources/information for practitioners including learning from case reviews on the following themes:

Parental Mental Health - Search results | NSPCC Learning:
Impact of Domestic Abuse - Search results | NSPCC Learning

Parental Substance Misuse - Search results | NSPCC Learning

ICON: Coping with Crying – see 7 minute brief on the next slide.

Coping with Crying

Background

None Accidental Injury (NAI) is the leading cause of major trauma in young babies. Abusive head trauma is part of this, and the peak age at which it happens is around six to eight weeks old, which corresponds to the age at which children cry most persistently.

Further Information

To find out more about supporting parents with coping with crying visit the ICON website at www.iconcope.org

The website has a number of useful resources for parents and practitioners and also offers training for professionals.

Crying curve

The 'Normal Crying Curve' shows how babies start to cry more frequently at about 2 weeks of age. The crying may get more frequent and last longer during the next few weeks, hitting a peak at about 6 – 8 weeks, sometimes a little later. Every baby is different but after about 2 – 3 months, babies start to cry less and less each week. Read more about the Crying Curve here

Impact of COVID

The ability to cope with stress depends on the controllability of the stressor. The measures to contain and delay the spread of COVID19 are already presenting major stressors for families which they cannot control such as a loss of income, isolation with children and potentially at risk adults, social distancing restrictions which may reduce support and increase stress. These additional stresses may increase a parents sensitivity to a crying baby.

6 Minute Conversations

ICON have produced a guide on key talking points that should take no longer than 6 minutes of professionals talking time and include 5 steps; infant crying is normal and will stop; comfort methods can sometimes soothe a baby and the crying will stop; it's ok to walk away once you have checked the baby is safe and the crying is getting to you; never ever shake or hurt your baby and finally ICON – Babies cry, you can cope

Practitioner Feedback

This is an extremely important message and I have found it really useful to have this conversation with families, especially during the antenatal period and on the postnatal ward, where we can give the message to mothers and engage their partners. I also feel that we are making a difference in supporting families when they go home; reassuring them that babies do cry and that this is normal.

Named Midwife for Safeguarding

Timing of Conversations

Every encounter with parents is an opportunity to discuss coping with crying, starting in the antenatal period and include both parents. Research shows the hospital based intervention is crucial in engaging men in conversations related to coping with babies crying. Visit the ICON website to more information on timings and resources to support.

Child Safeguarding Practice Review Panel Annual Report 2020

Patterns in practice, key messages and 2021 work programme

1. Who are the Child Safeguarding Practice Review Panel? The panel is the independent commissioner of reviews into serious child safeguarding cases with a view to improving learning, professional practice and outcomes for children. Statutory guidance in 'Working Together' sets out how the panel operates however the panel is independent of the government. The panel supervises the production and quality of reviews. The panel is chaired by Annie Hudson.

2. Annual Report 2020 Headlines. The report comprises information from all serious safeguarding incidents submitted to the National Panel in England throughout 2020. It acknowledged the unprecedented challenges of the COVID-19 pandemic and that agencies had to adapt rapidly to provide services.
Risk escalated where there were parental/family stressors, particularly for under 1s. Disrupted routines, overcrowding and increased pressures in households saw increased incidences of domestic abuse and poor mental health.
Schools play a crucial role in safeguarding and in lockdown some vulnerable children remained 'below the radar.'
Absence from school had a particular impact on young people's mental health and was evident in all cases where children took their own life.

3. Key Statistics 1.

- 482 serious incidents regarding 514 children (206 deaths, 267 serious harm and 9 Other e.g. child was perpetrator of harm).
- 53% of those referred were male and 46% female. 2 were transgender.
- 69% White British however when compared with census data there is a higher proportion of ethnic minority children referred.

4. Key Statistics 2.

- Predominance of infants under 1 (35%) followed by young people aged 15-17 (30%).
- Of the 206 deaths 17% were due to family maltreatment and 31% were Sudden Unexpected Deaths (SUDIC).
- Domestic abuse featured in 41% and neglect in 35% of cases where children died. Fathers were DA perpetrators towards mothers in 74% of cases.
- Poor parental mental health was evident in 146 serious incidents and mainly affected mothers (78%).
- Neglect was an underlying feature in 35% of fatal incidents and 34% of non fatal incidents. Recognising cumulative neglect remains an ongoing challenge.
- 16% of reported incidents included children with mental ill health.
- 51 incidents involved children engaged in risky/violent behaviour. 75% of these incidents were linked to gangs/county lines activities.

7. Safeguarding in Swindon.

The SSP is underpinned by guidance in Working Together 2018 and the Children and Social Work Act 2017. We plan and deliver a catalogue of safeguarding training to colleagues across Swindon in line with local need. We identify and oversee all learning reviews and CSPRs. We play a key role in developing local practice in line with our strategic priorities: Neglect, Exploitation and Early Help. We quality assure multi agency systems and practice to ensure the needs of children living in Swindon are met. Visit our website. Follow us on Twitter @SwindonSafegua1 or LinkedIn.

See our other 7 minute and practice briefs which provide information of several of the themes identified in this brief including professional curiosity, safeguarding adolescents, capturing the voice of the child in records, effective information sharing and consent.

6. Other National Publications.

'It was hard to escape' – Safeguarding children at risk from criminal exploitation (published March 2020)

'Out of routine' – a review of Sudden Unexpected Deaths in Infancy/Childhood (SUDIC) where children are at risk of harm (published July 2020)

Future publications:

Non accidental injuries to babies under the age of 1 – autumn 2021

Suicides; the secure estate and serious violence and Looked After Children (LAC)

https://www.gov.uk/government/organisations/child-safeguarding-practice-review-panel

5. Key Themes from 2020 Report

1) Continuous understanding of what the child's daily life is like and how that feels for them. Be mindful of all children (e.g. those who are non verbal) and that children may deliberately minimise difficulties.
2) Getting to the root cause of why families may be reluctant to engage.
3) Critical thinking and challenge in supervision, plans and assessments.
4) Responding to changing risks and needs – assessments should be reviewed when there is a significant change and should review known fragilities e.g. mental ill health.
5) Information sharing and that GDPR should not be a barrier. Some agencies remain unsure of what they can or can't share.
6) Organisations should create and sustain a culture of honesty, effective supervision and learning/development.

Summary: Key Findings

Impact of COVID-19

The need to respond to changing needs whilst ensuring COVID safe practice.

4 key factors that increase vulnerability;

- Parental and family stressors (particularly for babies under 1)
- Disrupted routines and overcrowding increasing pressures in the home
- Increased domestic abuse
- Increased mental health concerns

Impact from 1st lockdown reinforced crucial role schools play in safeguarding.

A window on the system

Of the 482 serious incidences 206 were in relation to child deaths and 267 related to serious harm.

35% of children were under 1 and a second peak of 30% in 15-12 year olds

There was a higher proportion of ethnic minority children among notifications to the panel. Particularly marked among black teens and mixed ethnicity of all ages.

Those from Asian ethnic groups were under-represented in all age groups compared to the general population.

Child deaths

of the 206 child deaths:

- 17% were caused by maltreatment within the family
- 8% were extra familial assaults or homicide
- 31% were sudden unexpected deaths in infancy
- 20% were suicides
- 9.7% were related to maltreatment
- DA featured in 41% of fatal cases
- Neglect was a feature in 35% of fatal cases

Serious harm

of the 267 serious harm notifications:

- 22% were due to physical abuse such as unexplained bruising or fractures
- 11% were young people involved in risk-taking or violent behaviour
- 10% were for child sexual abuse

Neglect was the primary form of serious harm.

DA was recognised in over 40% of incidents predominantly with father being the perpetrator and mother as victim.

16% of notifications for serious harm noted the child had experienced mental ill health.

Of the 11% involving risk taking and violent behaviour, 75% had evidence of gang violence or county lines activity.

Summary: Key Findings

Key Practice Themes

Report highlighted 6 key themes that are most urgent to address but also the most difficult.

The key themes are:

- Understanding what the child's daily life is like
- Working with families where their engagement is reluctant and sporadic
- Critical thinking and challenge
- Responding to changing risk and need
- Sharing information in a timely and appropriate way
- Organisational leadership and culture for good outcomes

These themes reflect the findings of the commissioned review of LCSPRs and Rapid Reviews.

A sense of the new working arrangements

Interest as to how safeguarding partners are facilitating effective and timely dissemination and embedding of learning.

Safeguarding partner arrangements have enabled a sharper focus on a smaller number of priorities and practice themes with a greater emphasis on quality assurance and leadership.

The evaluation of the impact of learning including training is a key area for development and this will be a focus for the panel in 2021.

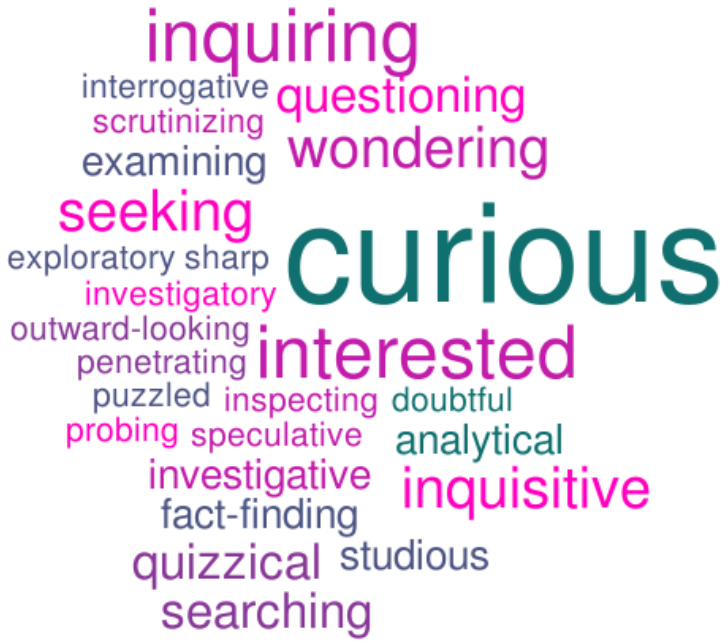
Quality of reporting and reviews

Considerable variation in the way local areas interpret the criteria for serious harm. Acknowledgment that this is a complex issue and the panel will be completing further work with partnerships.

Well conducted RR identify immediate learning, how and when it will be disseminated. Many RR does not use the analysis to inform immediate learning or provide a clear rationale for the aspects to review in a LCSPR.

Many LCSPRs seen to date are structured and read like SCRs with an insufficient focus on learning. Narrative often focuses on what happened rather than why it happened.

Professional Curiosity



What is professional curiosity?

It is the capacity and communication skill to explore and understand what is happening within a family rather than making assumptions or accepting things at face value.

It can require practitioners to think 'outside the box', beyond their usual professional role, and consider families' circumstances holistically.

Curious professionals engage with individuals and families through visits, conversations, observations and asking relevant questions to gather historical and current information.

See also SSP Practice Brief – Professional Curiosity

It is a combination of looking, listening, asking direct questions, checking out and reflecting on information received.

It means:

- testing out your professional hypothesis and not making assumptions
- triangulating information from different sources to gain a better understanding of individuals and family functioning
- getting an understanding of individuals' and families' past history which in turn, may help you think about what may happen in the future
- obtaining multiple sources of information and not accepting a single set of details you are given at face value
- having an awareness of your own personal bias and how that affects how you see those you are working with
- being respectfully nosey

Why is it important?

Professional curiosity is a golden thread through Safeguarding Partnership learning reviews and audits and is an essential part of safeguarding. Nurturing professional curiosity is a fundamental aspect of working together to keep children, young people and adults safe.

A lack of professional curiosity can lead to:

- missed opportunities to identify less obvious indicators of vulnerability or significant harm
- assumptions made in assessments of needs and risk which are incorrect and lead to wrong intervention for individuals and families
- the presenting issues are dealt with in isolation

Professionals asking questions and seeking explanation from parents/carers is something to be valued; healthy challenge is good and can provide assurance that your assessment of the situation is accurate.

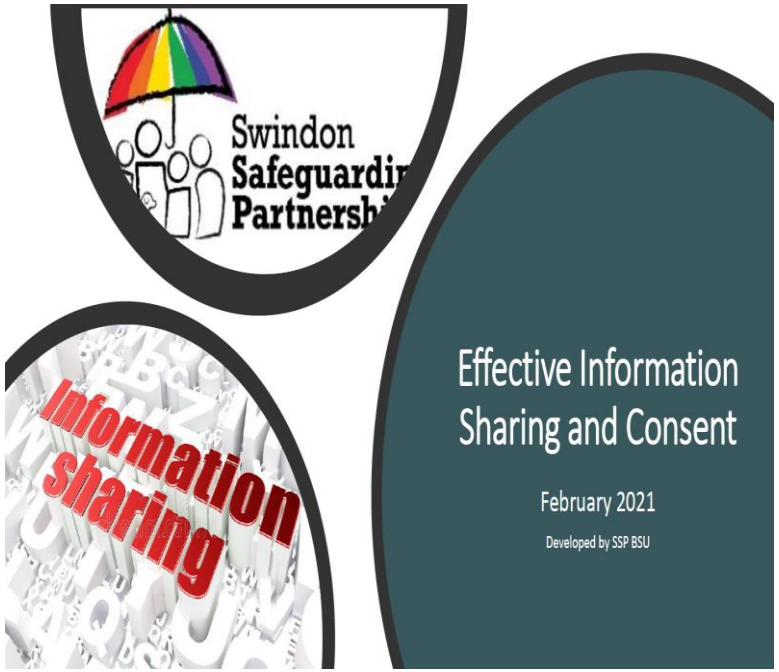
A high reliance by professionals on self-report by parents/carers brings with it significant risks of proceeding on false information.

Good information sharing, supervision and open discussion at key decision-making meetings to 'check and test' information can be crucial in ensuring this does not happen.

Please familiarise yourself with the information and guidance detailed in the

SSP Practice Brief – Professional Curiosity

Theme: Information sharing



Please refer to the SSP Practice Brief for further information: [Effective information sharing and consent - Swindon Safeguarding Partnership]

Golden thread identified in audits, case reviews both locally and nationally.

- Effective information-sharing underpins integrated working and is a vital element of both early intervention and safeguarding.
- Research and experience have shown repeatedly that keeping children safe from harm requires practitioners and others to share information about:
- A child's health and development and any exposure to possible harm;
- A parent who may need help, or may not be able to care for a child adequately and safely; and
- Those who may pose a risk of harm to a child.
- Often, it is only when information from a number of sources has been shared and is then put together, that it becomes clear that a child has suffered, or is likely to suffer, significant harm.
- Practitioners should be proactive in sharing information as early as possible to help identify, assess and respond to risks or concerns about the safety and welfare of children.
- This includes when problems first emerge, or where a child is already known to local authority children's social care (e.g. they are being supported as a child in need or have a child protection plan).

Source: [South West Child Protection Procedures]

Swindon Safeguarding Partnership

SSP Policies and Procedures

Multi-Agency Child Protection Standards Revision to Unborn Baby Protocol

Title: **MULTI-AGENCY CHILD PROTECTION STANDARDS FOR SAFEGUARDING CHILDREN**

Swindon Safeguarding Partnership

What are the Child Protection standards? They provide a framework for professionals & families to understand how organisations work together to safeguard children. Providing clear guidance and expectations around agency responsibilities and expectations for supporting the CP process, such as strategy discussions, section 47 enquiries, child protection conferences and core groups.

CHILD PROTECTION PLAN/CORE GROUPS: Each child having suffered/likely to suffer significant harm must have a Child Protection Plan which addresses risk factors identified at a CP conference. An outline plan agreed at conference will be developed by the Core Group. A meeting of professionals who are equally responsible for keeping the CP plan updated & co-ordinating inter-agency activities.

CHILD PROTECTION CONFERENCES: convened when a child is considered at risk of significant harm, brings together family members (the child, if appropriate), supporters/advocates & professionals to plan & review how best to reduce the risk. Expected standards & criteria include timescales, quoracy, participation of parents/carers, wishes of the child, information sharing, decision-making regarding threshold for CPP is met & category of abuse. Also agreeing core group members & dates of meetings.

SECTION 47 ENQUIRIES: initiated to determine whether a child is suffering/likely to suffer, significant harm and action required to safeguard the child. They are carried out by undertaking an assessment. The expected standard and criteria are outlined, such as enquiries being social worker led with full engagement of relevant professionals, adherence to timeliness, speaking to the child alone, drawing conclusions regarding the child suffering/likely to suffer significant harm and the ongoing risks. One outcome of a section 47 is to escalate to an initial child protection conference where intervention at a lower level cannot be achieved.

Why do we need standards? No one agency / professional can effectively keep children safe and they are best protected when professionals have clarity about what is required of them individually and are working together. This includes a shared commitment, effective communication & focus on achieving the best outcomes for the child. To be read in conjunction with SSP thresholds document, Right Help @ the Right Time, SW Child Protection Procedures and local SSP Policies & Procedures.

Child-Centred Approach - Expected standards – i) needs of the child kept at the centre of all safeguarding processes, ii) Children seen alone & where possible time taken to develop their trust, iii) 'Think Family' however analysis focusing on the impact of adults behaviour & lived experiences of the child, iv) which professional is best placed to work with the child, v) focus of all activity is securing the best outcomes for the child, not completion of processes.

Multi-Agency Strategy Discussion: usually held following referral or assessment, which indicates a child has suffered, or is likely to suffer, significant harm. To decide whether there are grounds for a S.47 Enquiry, to determine a child's welfare & plan rapid future action if a child is suffering /likely to suffer significant harm. Each section outlines the expected standard and criteria, such as timescales, quoracy, agenda for the meeting, professional roles and responsibilities, action plans and outcomes.

To access the Child Protection standards please click here

Revision to Unborn Baby Protocol

The Updated SSP Unborn Baby Protocol Working with Parents to Safeguard the Unborn Baby has now been published and can be accessed here.

The purpose of the protocol is to provide **all professionals** with guidance regarding the safeguarding risks to unborn babies across the 'continuum of need' (The Right Help at the Right Time) to plan appropriate support and intervention.

It will also assist with decision making around completing a safeguarding referral to children's social care for an Unborn baby and when undertaking pre-birth assessment.

There are changes to the protocol such as Legal Planning and Safeguarding Birth Plan and revisions to the templates.

Please familiarise yourself with the content and disseminate to colleagues.

Useful Resources: Learning Themes

Please refer to the SSP Practice Brief for further information. This includes capturing the voice of the unborn baby and the voice of babies/young children. Voice of child in records

- See also the overview of Themes from Serious Case Reviews and Audits
- Access all SSP 7 minute briefs and practice briefs examples of themes include Safeguarding Adolescents Resource Pack
  - Professional curiosity
  - Neglect framework and practice guidance
  - Graded Care Profile2 (GCP2) and Graded Care Profile2 Antenatal (GCP2A)
  - Safeguarding Children Oral Health
  - Professional disagreement/escalation

  This list is not exhaustive and we are continually adding resources so please visit the webpage.

- SSP Child Protection Conference Induction Pack_220621 - Swindon Safeguarding Partnership
- You should also refer to the SSP Children and Young People Policies and Guidance available on the Swindon Safeguarding Partnership website and South West Child Protection Procedures
- Further information available about reporting safeguarding concerns

Learning from audits – Strategy Discussions

Strategy Discussions

Background

In March 2021 an audit was conducted on strategy discussions that were held for children under the age of 1. Recent Rapid Reviews have highlighted common themes with strategy discussions including timeliness of communication, information sharing and decision making that involves all agencies. The audit identified some key areas of learning which are explored further within this 7 minute briefing.

Impact of COVID-19

The impact of COVID-19 on all children has been significant and the impact of the pandemic will be felt for years to come. It is important to consider how the COVID-19 pandemic may have impacted on a child and their family.

Voice of the Child

The voice of the child is important and hearing the voice of a child who can not verbalise their thoughts and feelings requires practitioners to be the voice of the child. This can be explored by looking at parent-child interaction, how they act around familiar adults. Find out more about capturing the voice of the child here

Jargon

The use of jargon is common place in every professionals day to day work and there are occasions where it can be useful. However, it is important practitioners are mindful of other multi – agency partners, children and families understanding of our professional jargon and ensure information is fully explained. For tips on managing the use of jargon click here

Fathers

When fathers do not live within the family home they can often be forgotten however, they play a key role in their children's lives and should be given equal consideration to other adults within the home. **Think** – Have I considered the children's father in this discussion?

Analysis of Risk

The ability to analyse the risks is an integral aspect of a practitioners contribution to Strategy Discussions. Effective analysis of information goes beyond describing what is happening and relies on a practitioners expert to interpret the risks posed to the child based on the information. It may be helpful to consider any relevant theories or research along with the knowledge of a child's general health, wellbeing and development stages.

Explicit Identification of Risks

The purpose of a Strategy Discussion is to decide whether there are grounds for a Section 47 Enquiry and determine the child's welfare and plan rapid future action if there is reasonable cause to suspect the child is suffering or likely to suffer significant harm. Therefore, it is essential that the risks to the child are clearly named within the strategy discussion and the records reflect the conversations regarding risks identified.

The hyperlinks in the 7 minute brief above are included here for ease of access:

Link to managing the use of jargon click here

Capturing the voice of the child in records

To access this 7 Minute Brief click here.

Reflection

Having reviewed this document consider the following:

✓What aspect of this information/learning has had the most impact for you.
✓What will you do differently in your practice as a result.
✓What will you tell your team/colleagues about.

We would really like to hear your feedback on this resource please take a few minutes to complete an evaluation form. Click here to access.