Swindon
Safeguarding
Partnership

Core Module Child:
Learning from case reviews and audits

Housekeeping

- Cameras and microphones off
- Questions at the end
- Webinar will be recorded

Aims/Context

Explore the themes and learning identified in national and local case reviews and audits and reflect on how this impacts on your practice.

The themes identified include:

- Suspected injuries to mobile and non-mobile babies
- Brief Unresolved Events
- ICON (a programme that provides information about infant crying and how to cope)
- Working with Fathers
- Impact of COVID-19

There will also be an update and overview of the following procedures/documents:

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

Rapid Reviews

Background

Working Together 2018 places a duty on local Safeguarding Partnerships to undertake a rapid review for serious child safeguarding cases where: *Abuse or neglect of a child is know or suspected ; and the child has died or been seriously harmed.*
*When a serious child safeguarding case is referred to Swindon Safeguarding Partnership , we have **15 working days** to complete the rapid review and notify National Panel of the outcome of the meeting.*

Swindon Safeguarding Partnership

What is the Purpose of a Rapid Review?

The purpose of a Rapid Review is to assemble the facts of the case as quickly as possible in order to establish whether there is any immediate action needed ensure a child's a safety and the potential for a National or local Child Safeguarding Practice review.

Who contributes to a Rapid Review?

Any agency that has been involved with the child or family and members of the Practice Review Group. Within **2 working days** of the referral being received by the SSP Business Unit, initial scoping and information requests will be sent to the PRG members and any other agencies identified working with the child/family.

What does my agency need to do?

Within the agreed timescale notified to your agency the completed initial scoping template must be securely submitted to the SSP Business Unit at: safeguardingpartnership.swindon.gov.uk At this stage agencies must secure their records relating to the case. This information will then be shared with those attending the Rapid Review meeting, if your agency is identified as a key agency a representative may be asked to attend.

What happens next?

A Rapid Review meeting will take place to review the facts of the case, Agree any immediate action in regards to safeguarding, decide if the case Meets the criteria for a National/Local Child Safeguarding Practice Review or other learning review.

What happens after the Rapid Review meeting?

Within the relevant timescale of the Rapid Review meeting taking place the National Panel are notified of the review panels recommendations in terms of whether or not the information scoped meeting the criteria for a National/Local review or other review.

What happens after the Rapid Review meeting?

If a decision is reached to conduct a full safeguarding review and this Is endorsed by the National Panel, agencies will be contacted to Engage with the review. If a local or other type of review is agreed The SSP Business Unit will coordinate this as per agreed decision.

Suspected injuries to mobile and non-mobile babies

Natalie Herring

Named Nurse for Children's Safeguarding, Swindon Borough Council

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?

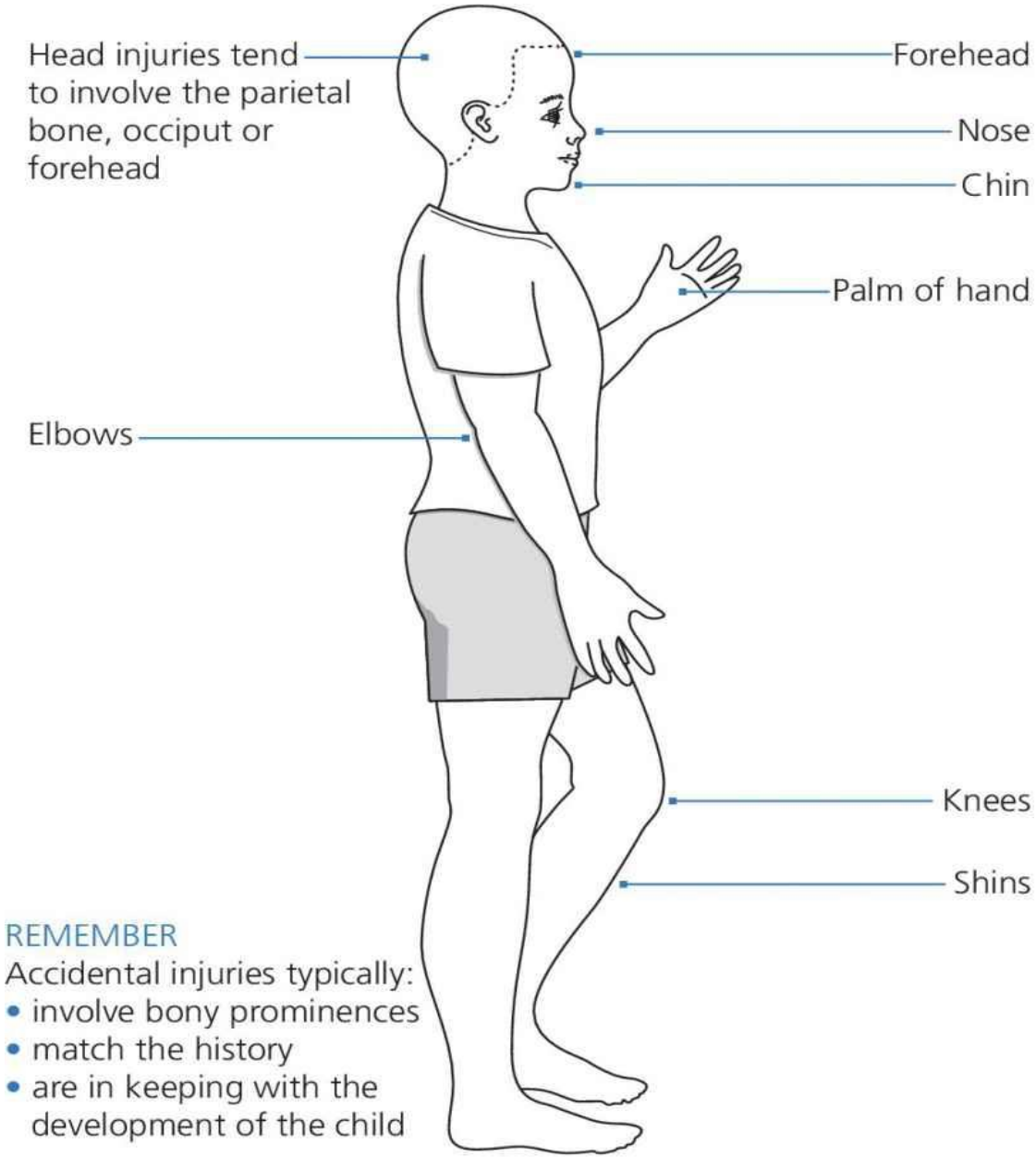
Is the injury consistent with child's developmental stage?

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

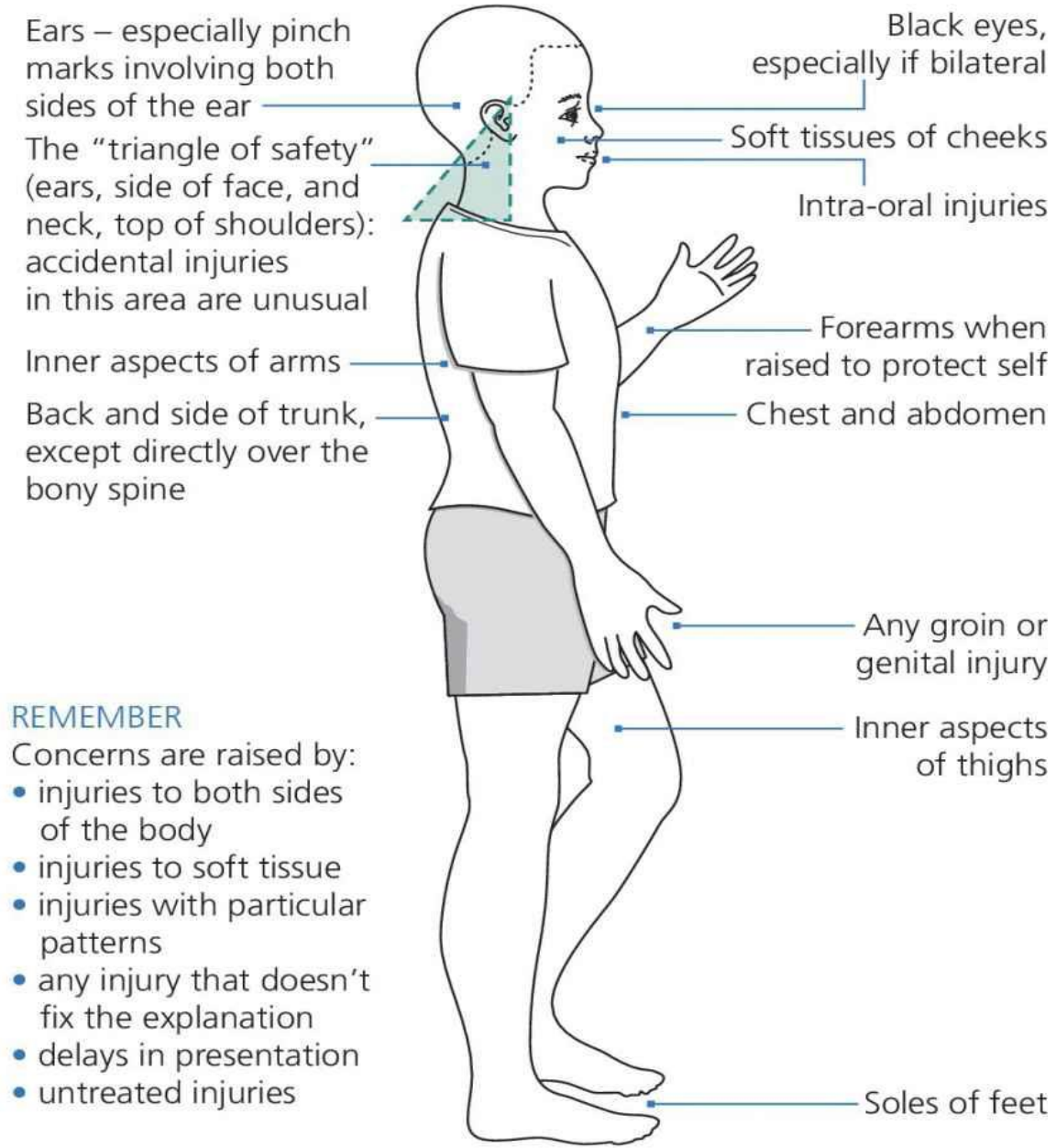
Use of professional judgement

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.

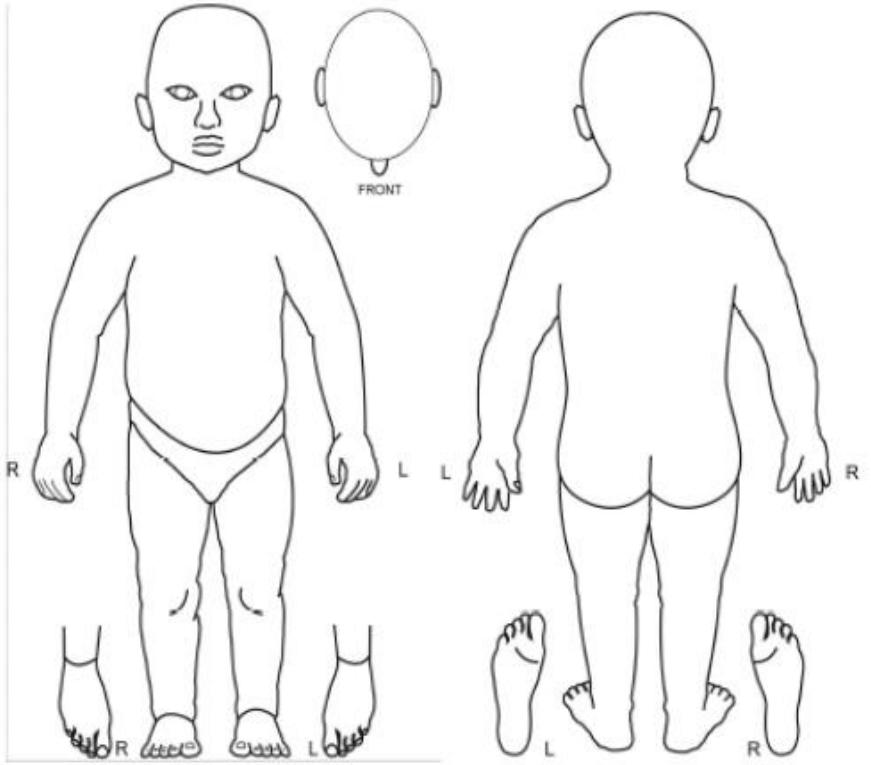


(a) Typical accidental injuries



(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:**

Bruising in Non- Mobile Infants

- The policy for Swindon can be accessed on the Swindon Safeguarding Partnership website in the Children and Young People's Policies section
- The policy title is "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

Something BRUE-ing?

Dr Claire Broomfield

Consultant Paediatrician

Named Dr Safeguarding Children

Case Study

Zoe is a 10 week old infant brought in by ambulance to ED.

- Parents report she suddenly became pale and “floppy” at home and they think she may have stopped breathing for around 30seconds before returning to her “normal” self.

ALTE vs BRUE

	Apparent Life Threatening Event - 1986	Brief Resolved Unexplained Event – 2016
Age	No particular limit	<1yr age
Airway	Choking/gagging	Not included in definition
Breathing Pattern	Apnoeic	Absent/Diminished or Irregular
Circulation (colour)	Cyanotic/Pallor/Red	Cyanotic/Pale
Disability (Tone/Consciousness)	Not specified	Marked change in tone/Altered conscious level
Causes	Might have included GORD/Sepsis	Only if no other cause found DIAGNOSIS OF EXCLUSION

BRUE

- Infant < 1 year age
- BRIEF <1 minute
- Fully RESOLVED
- UNEXPLAINED EVENT – not due to underlying medical cause
- 1 or more of the following:
  - Cyanosis/Pallor
  - Absent, decreased or irregular breathing
  - Marked change in tone (hypo/hyper)
  - Altered level of consciousness

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

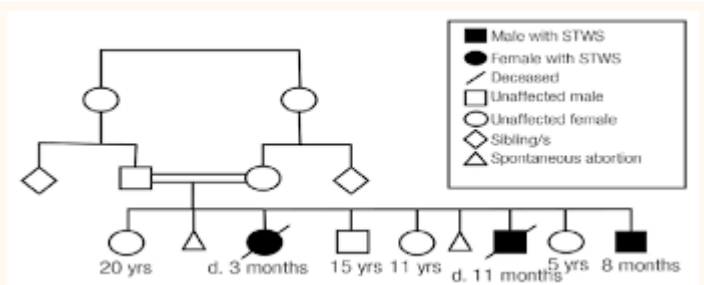
- Choking/Gagging?
- Child active, floppy or stiff?
- Any repetitive movements observed -?seizure
- Breathing pattern
- What was skin colour?

END Of EVENT

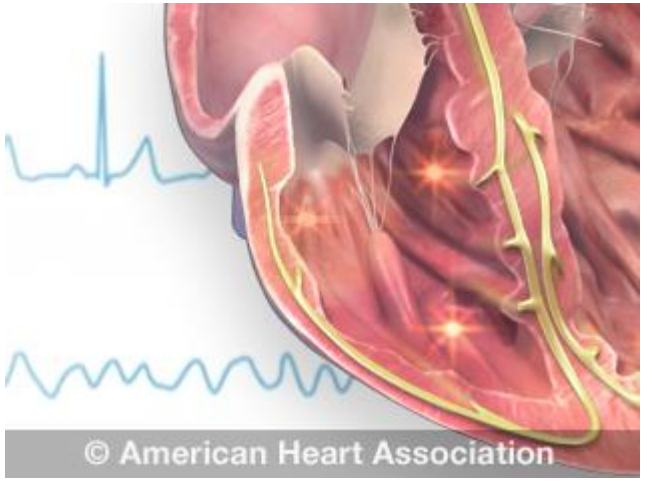
- Duration
- How did it stop?
- What did caregiver do?
- When/how was medical help obtained?
- Are they back to normal self?

History is Key!

Inborn Errors Metabolism

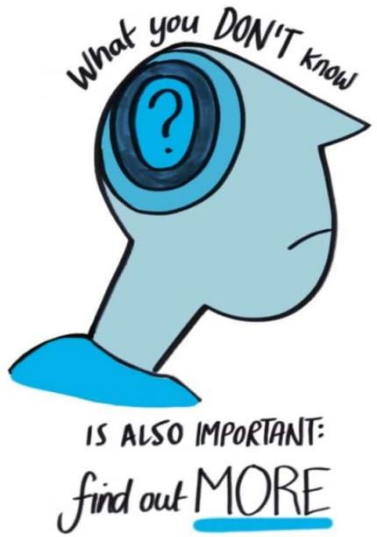


Gastro-oesophageal Reflux



Arrhythmia

Professional Curiosity



Family/Social Factors

- Supervision around the event
- What do you know about the family?
  - Known to SS
  - Mental health/substance misuse
  - Frequent attendances child/siblings?
  - Recent stresses?
  - Risk factors for infant (ACES, DV, socioeconomic)
  - Was there a delay in presentation to healthcare?

Think SAFEGUARDING

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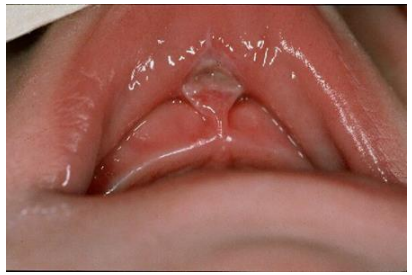
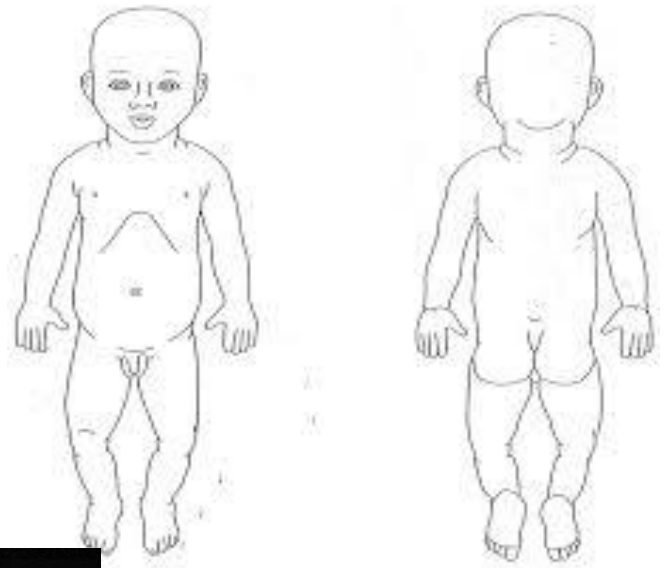
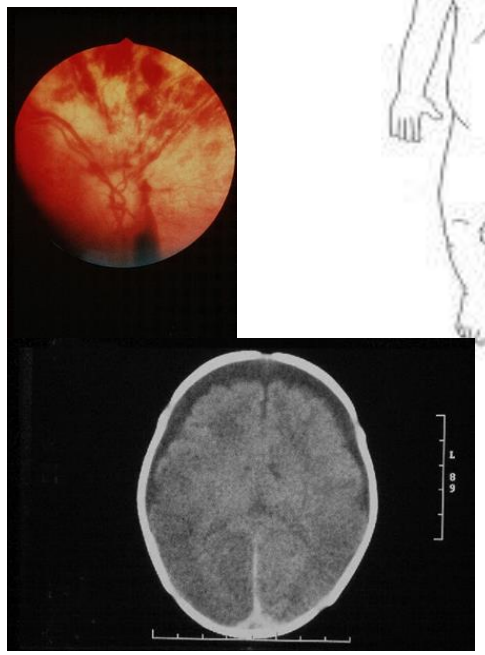
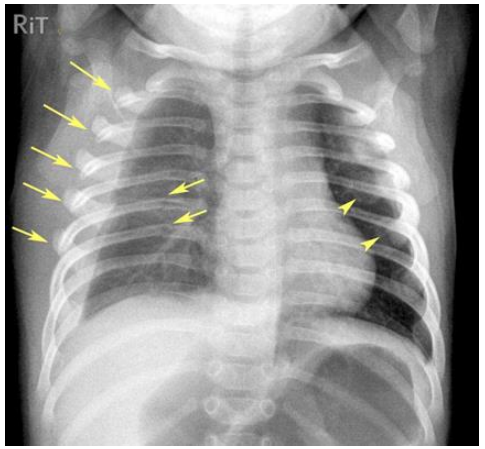








NOT A BRUE IF….

- Identifiable cause found
- Abnormal examination findings
- Safeguarding concerns identified

<u>Learning From SCR:</u>

-admitted overnight for observation; normal initial investigations. Families not known to SS. HOWEVER….

-abnormal examination findings – no red book for comparison of OFC

-duration of event and recovery

--previous attendance with similar event and suspected GOR

-rib # on CXR - importance of risk stratification/indication

coping with crying

Risk Stratification

Normal examination and no cause identified:

LOW RISK BRUE:

- ✓ No Red Flags in hx
- ✓ Age >60days
- ✓ Born ≥32 weeks gestation
- ✓ No CPR performed by trained healthcare
- ✓ First event & no FHx
- ✓ Duration < 1 minute

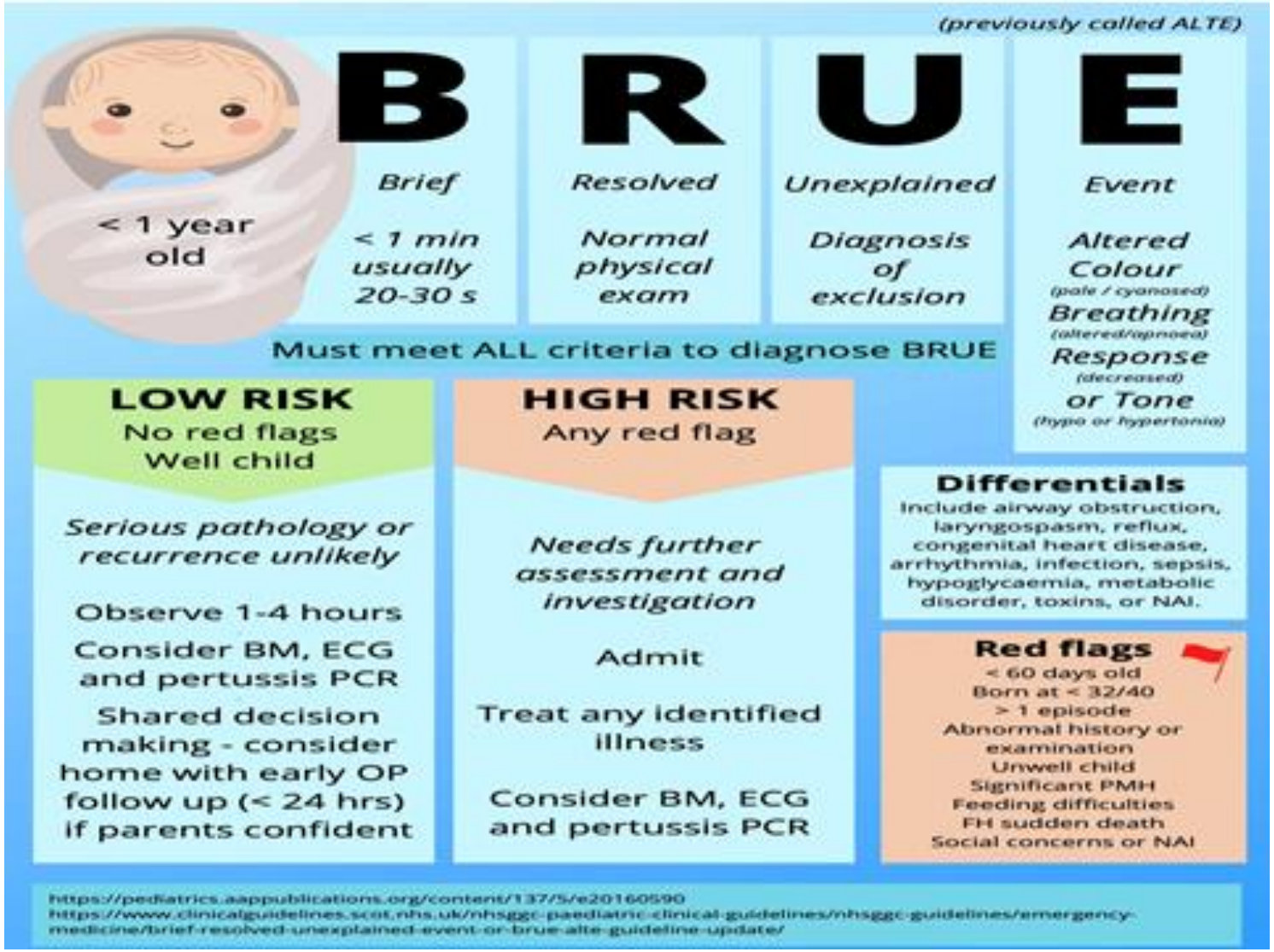
Zoe , 10 weeks old

LOW RISK BRUE:

1. ECG + Blood Glucose
2. Observation 1-4 hrs
3. Senior Paediatric Review
4. Follow Up :HV/GP/PAU

SAFETY NET ADVICE

Summary…..


(previously called ALTE)
< 1 year old
B
Brief
< 1 min usually 20-30 s
R
Resolved
Normal physical exam
U
Unexplained
Diagnosis of exclusion
E
Event
Altered Colour
(pale / cyanosed)
Breathing
(altered/apnoea)
Response
(decreased)
or Tone
(hypo or hypertonia)
Must meet ALL criteria to diagnose BRUE
LOW RISK
No red flags
Well child
Serious pathology or recurrence unlikely
Observe 1-4 hours
Consider BM, ECG and pertussis PCR
Shared decision making - consider home with early OP follow up (< 24 hrs) if parents confident
HIGH RISK
Any red flag
Needs further assessment and investigation
Admit
Treat any identified illness
Consider BM, ECG and pertussis PCR
Differentials
Include airway obstruction, laryngospasm, reflux, congenital heart disease, arrhythmia, infection, sepsis, hypoglycaemia, metabolic disorder, toxins, or NAI.
Red flags
< 60 days old
Born at < 32/40
> 1 episode
Abnormal history or examination
Unwell child
Significant PMH
Feeding difficulties
FH sudden death
Social concerns or NAI
https://pediatrics.aappublications.org/content/137/5/e20160590
https://www.clinicalguidelines.scot.nhs.uk/nhsggc-paediatric-clinical-guidelines/nhsggc-guidelines/emergency-medicine/brief-resolved-unexplained-event-or-brue-alte-guideline-update/

ICON – Coping with Crying

Kate Clements

Named Midwife for Safeguarding

Great Western Hospital

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.

Working with Fathers

Natalie Herring

Named Nurse for Children's Safeguarding, Swindon Borough Council

Working with Fathers

It's well-established that fathers matter.

Society is changing in how we view fathers and their roles

It is no coincidence then 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'.

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.

The Myth of Invisible Men 2021 CSPR Panel

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.

Review Findings:

Approx 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

Child Safeguarding Practice Review Panel Annual Report 2020

Jade Batten
Safeguarding Development Manager
Swindon Safeguarding Partnership

Review Panels 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

Review Panels 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.

Unborn Baby Protocol Revision

Joanne Smith
Named Nurse for Safeguarding Children
Great Western Hospital

Unborn Baby Protocol Revision

- New Revision

- Main Changes:-
  - Legal Planning
  - Safeguarding Birth Plan

- Cascading to your teams

Multi- Agency Child Protection Standards

Fiona Francis

Service Manager, Safeguarding and Quality Assurance & Review Service

Swindon Borough Council

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.

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 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.

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

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.

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

Useful additional resources

- 7 minute briefs and practice briefs
- Professional curiosity
- Voice of child in records
- Information sharing and consent
- CSPR Annual Report 2020 Headlines
- Themes from Serious Case Reviews and Audits

Reflection

Having attended this session today consider the following:

✓What aspect of this session has had the most impact for you.
✓What will you do differently when you get back to work.
✓What will you tell your team/colleagues about.

We really want your feedback so please complete the evaluation form – it will take about 5 minutes.

Learning From Case Reviews and Audits

Thank you

Any Questions?