HSCP Executive Summary

Safeguarding Infants Thematic Review 2022

This Executive Summary was developed to highlight the key findings of the HSCP Safeguarding Infants thematic review and share learning across the Hampshire workforce.

The Safeguarding Infants thematic review looked at the partnership understanding and response to safeguarding infants in Hampshire utilising various methodologies. The aim was to establish a holistic view of current work, promote best practice and identify any areas that require strengthening. The four areas of focus for this review were;

Unborn/Newborn Baby Protocol *

Protocol for the management of actual or suspected bruising or other injury in infants who are not independently mobile (Bruising Protocol)

ICON (Abusive Head Trauma) programme

Every Sleep Counts programme

**The audit also includes the Hampshire-only process that was introduced in 2021, where all cases referred under the Unborn/Newborn Baby Protocol are kept open to Children's Services three months post-birth.*

This review has highlighted the strength of partnership working within Hampshire to safeguard infants. The protocols and programmes of work are effective in supporting professionals to deliver key messages, risk assess and safety plan when required.

The protocols provide professionals with a framework which instils confidence when working with families where risk has been identified. Positive practice was identified throughout the thematic review including services provided to Hampshire families and protocols/ processes developed as a result of learning from previous reviews.

Some of the themes arising from this review are not specific to infants and are seen in other audits/case reviews. These include the importance of record keeping, detailing decisions and their rationale, information sharing (in terms of outcomes and safety plans) and the necessity of good quality referrals.

The importance of recording birth marks/injuries and details of delivery as per newborn and infant physical examination (NIPE) guidelines featured in several of the case file audits as well as during practitioner conversations. It is crucial that this information is documented to reduce unnecessary referrals under the Bruising Protocol. In two of the unnecessary referral cases, adverse impacts on the family were noted as a result of the process.

Housing issues were identified in the top five most prevalent risk factors in the review of Hampshire SCR/MAR recommendations. With the challenges currently facing many families, consideration should be given to how housing issues can impact families and whether it could, in individual cases, increase risk.

This review has highlighted the need to continually promote the work undertaken in Hampshire to safeguard infants, ensuring that when professionals are working with families with children under 1, that they are fully aware of the programmes/protocols available to support them in their role.

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Key Findings

310 professionals across different agencies completed the staff survey.

75%	**were aware of or had used the UBB protocol**
87%	**were aware of or had used the Bruising Protocol**
60%	**were aware of or had delivered the ICON programme**
70%	**were aware of or had delivered the ESC programme**

"It supports us to make referrals and speak with parents regarding this process, gives structure and guidance".

".. it allows me to fully discuss safe sleep with parents in a non-judgemental way. This way, parents are open to discussion about it and feel they can discuss previous times or thoughts on co-sleeping, which can then be explored further, and further advice can be given".

"ICON has helped me recognise that injuries to young children are not always visible but there are other warning signs to look out for in the baby, in the parents, in the home environment".

Significant work has been undertaken as a result of recommendations from local reviews including updates to the Bruising and Unborn Baby protocols, the development of the ICON and Every Sleep Counts programme, training including numerous sessions on known risk factors and safeguarding infants (Training - Hampshire SCP) and the development of an unidentified adults toolkit.

A desktop review of 55 cases, including referrals into Hampshire's learning and Inquiry Group, cases reviewed by CDOP where unsafe sleep was a presenting factor and national Serious Case Reviews highlighted five areas of risk as being the most prevalent in this snap shot review, these were;

58%	**Parental mental health**
51%	**Parental substance misuse**
49%	**Previous parental convictions** (*predominantly violent offences or theft)*
44%	**Domestic Abuse**
44%	**Housing issues** *(including homelessness, temporary accommodation, overcrowding and in one case significant rent arrears)*

Whilst these cannot be used as predictors of abuse it is important that professionals are aware of the potential for increased risk when assessing families. In the 19 case file audits that were undertaken on the Bruising and Unborn Baby protocol the panel concluded that in all cases the infants were safeguarded. The audit highlighted the importance of following the protocol to support information sharing and joint working to safeguard infants. Of the upmost importance was the need for clear and accurate record keeping including decision making and rationale being detailed within case notes.

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What are we doing?

The thematic review identified a number of actions to be undertaken by the partnership and partner agencies to further strengthen the work undertaken in Hampshire to safeguard infants. These include;

- Sharing the findings of this review through a summary to raise awareness with professionals
- Developing a safeguarding infants group who will create a toolkit including the four areas of focus for this review for both professionals and parents/ carers where all information is accessible and work on promoting awareness of the different workstreams.
- A group will be established to look at the findings from the local and national reviews to identify any additional tools that may support professionals in identifying/ assessing risk.
- Asking health providers to assure HSCP that emerging birthmarks/ birth injuries are clearly recorded in notes.
- Asking agencies to support their staff in undertaking record keeping training internally or via the HSCP eLearning platform.
- Asking agencies who refer under the bruising protocol to follow up a telephone referral with an Inter-Agency Referral Form (IARF) on the same day to ensure clear concise information is shared.

Key Messages for Practitioners

1. Make sure you are aware of the **HIPS Unborn/Newborn Baby Protocol** and your role and responsibilities. This protocol supports the effective sharing of information.

2. Refresh your knowledge of the **Protocol for the management of actual or suspected bruising or other injury in infants who are not independently mobile**.

3. Be familiar with HSCP Safeguarding Infants programmes such the **ICON (Abusive Head Trauma) programme** and the **Every Sleep Counts programme**

4. Make sure your recording keeping training is up to date. You can access the training via your own agency or via HSCP eLearning - **Training - Hampshire SCP**

ICON

Every Sleep Counts