Vulnerability in under ones national and local context

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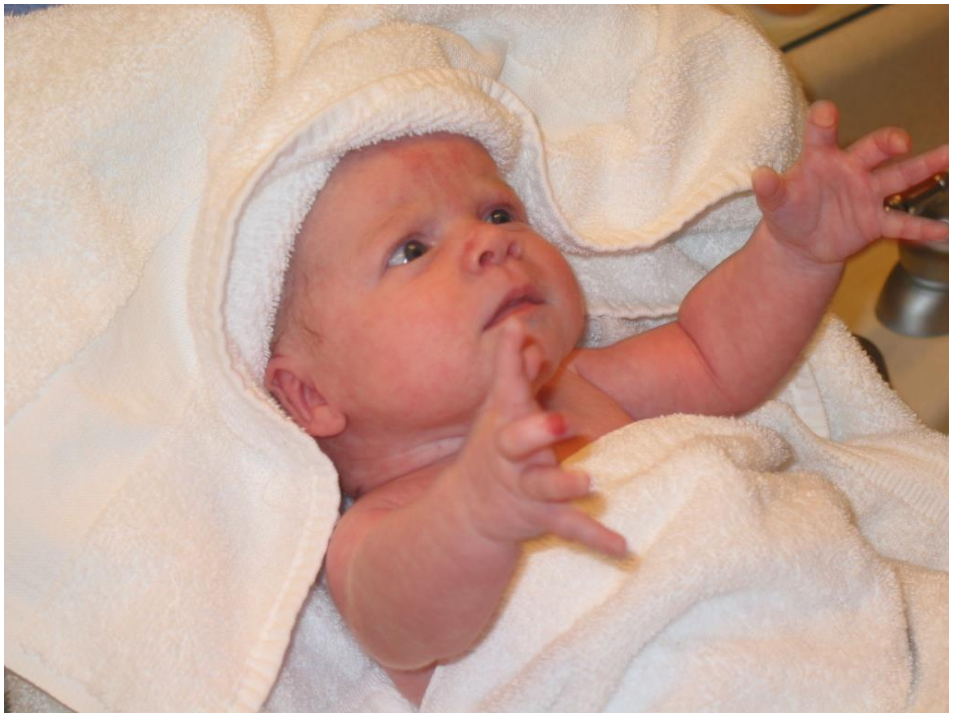
Parental risk factors

- 144,000 babies under one year live with a parent who has a common mental health problem
- 93,500 babies under one year live with a parent who is a problem drinker
- 39,000 babies under one year live in households affected by domestic abuse in the last year
- 19,500 babies under one live with a parent who has used Class A drugs in the last year

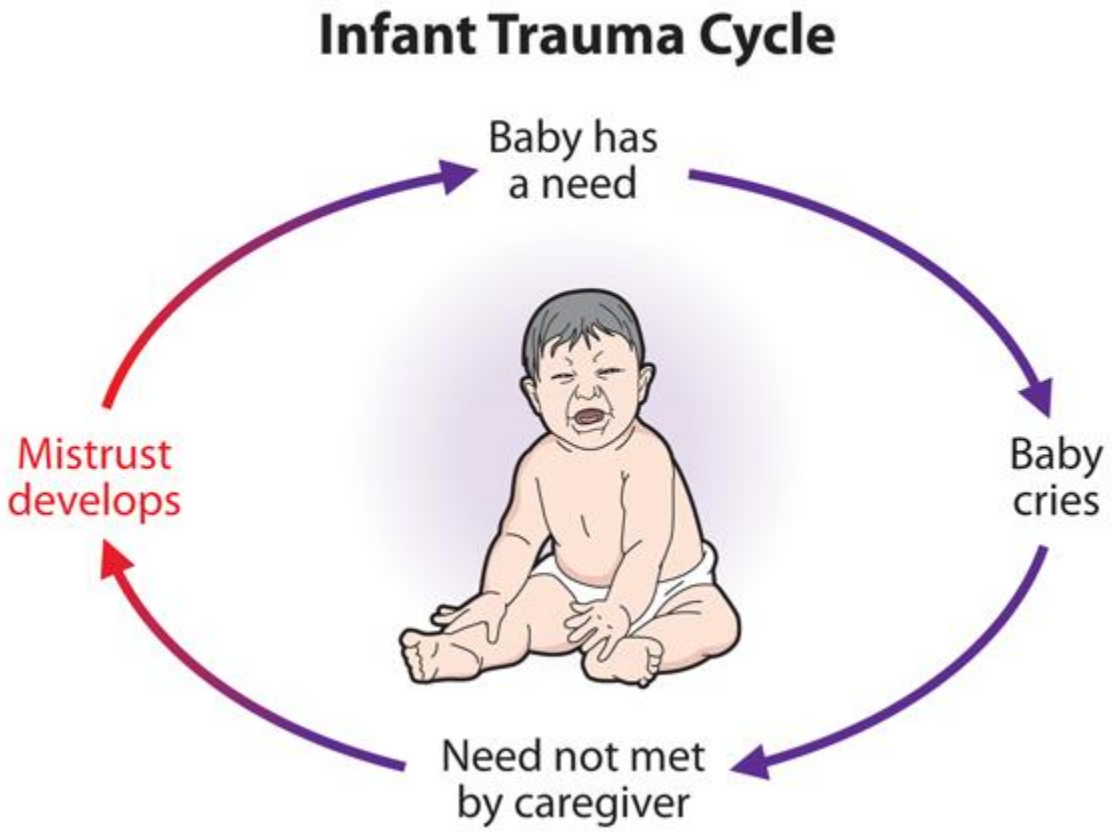
(All Babies Count Report NSCPP 2011)

Infant Vulnerability



- **Particular risks:**
  - Prematurity
  - Disability
  - Traumatic birth
  - Unwanted pregnancy

Parent child interaction



Triggers

- Crying baby
- Feeding issues/frustration
- Baby who won’t sleep
- Perception of child's behaviour
- Argument/family conflict
- Caregiver stressors outside the home, including financial concerns, job loss, legal trouble, relationship problems

Wiltshire context

- 50% referrals to SCR <1 year
- 3/5 relate to young parents
- 4/5 first time parents
- 4/5 father with violent history/ drug history
- 4/5 mother emotional or mental health problems
- 4/5 history of domestic abuse
- 3/5 homeless or in temporary housing
- 4/5 had previous referrals to Mash
- 2/5 Subject to CPP

Wiltshire context

Case 1: 5 weeks poor gain, 6 weeks bleeding gums, 7 weeks bruised abdomen

Case 2: 4 months subdural haemorrhage

Case 3: 5 months head injury

Case 4: 2 months bruising to buttock – fractured tibia

Case 5: 3 weeks bruised cheek , 6 weeks further bruise to cheek

Under 1's (Child protection evidence – systematic review)

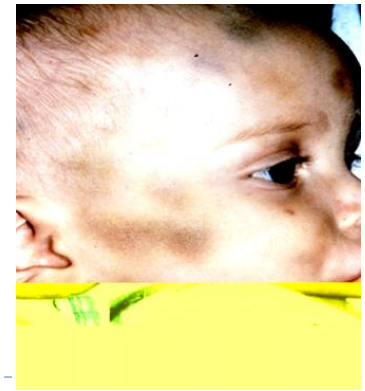
- Bruising in a baby who has no independent mobility is very uncommon
- Severe child abuse is 6 times more common in babies aged under 1 year than in older children
- Infant deaths from non-accidental injuries often have a history of minor injuries prior to hospital admission e.g. bruising

Bruising indicative of abuse

- Bruising in babies
- Multiple bruises in clusters
- Multiple bruises of uniform shape
- Bruises that carry the imprint of implement or a ligature
- Bruises that are seen away from bony prominences
- Bruises to face, abdomen, arms, buttocks, ears, neck, and hands

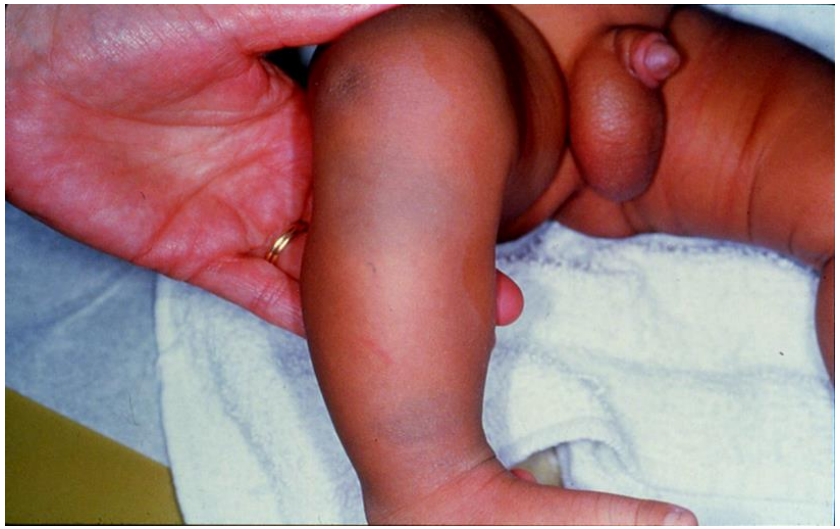
Bruises

- It is not possible to age a bruise by examining it with the naked eye
- Considerable variation in the way different observers interpret and describe colour
- The accuracy of estimating the age of a bruise to within 24 hours is only 40%
- Different colours appear in the same bruise at the same time
- Not all colours appear in every bruise



Differential diagnoses

- Birth marks - haemangiomas; mongolian blue spots
- Infections e.g. scabies
- Bleeding disorders
- Osteogenesis imperfecta

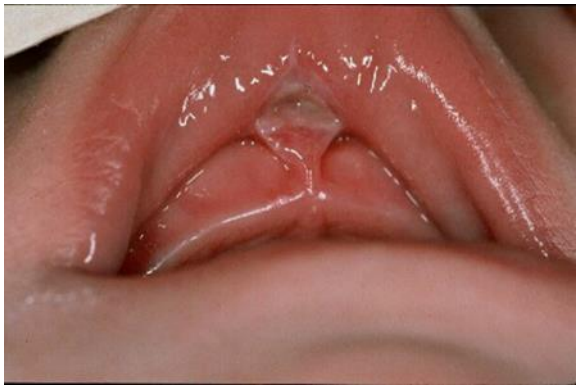


Multi-agency working

- A bruise should never be interpreted in isolation and must always be assessed in the context of the child's medical and social history, developmental stage and explanation given
- Multi-agency information sharing allows for sensible, informed judgements regarding the child's safety to be made

Is a torn labial frenum diagnostic of physical child abuse?

- A torn frenum is frequently described as pathognomonic of child abuse
- Many mechanisms are proposed, including force feeding, twisting and direct blow
- It is a trivial oral injury in dental terms



Child protection evidence – oral injuries

- A child with a torn frenum should undergo a full child protection evaluation but if no other injuries nor any social concerns are identified, the presence of a torn frenum alone is not diagnostic of physical abuse
- Investigation to exclude other injuries
- An accidental torn frenum should be a memorable injury for parents, as there is likely to be considerable bloody saliva from the child's mouth following the injury

What probing questions would you ask parents……?

- 1. Baby who cries a lot
- 2. Baby who has feeding difficulties
- 3. Baby who won’t sleep
- 4. Baby who has a small bruise on his cheek
- 5. History of domestic violence
- 6. Mother has mental health problems
- 7. Parents who use drugs and alcohol

Prevention : Crying - What can I do?

- Help parents understand it's okay for a baby to cry—it's how they communicate! It doesn't mean the baby dislikes them
- Help parents understand it is normal to feel frustrated by a crying baby—and it is okay to take a break and ask for help. Have an action plan for when frustration becomes overwhelming
- Know local services

Prevention :Feeding - What can I do?

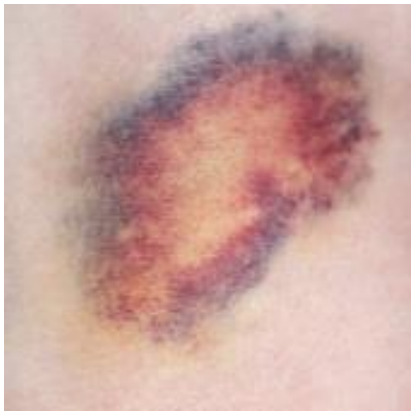
- Help parents understand that babies can be slow to feed and may be sick
- Can be a lovely bonding time, can be exhausting and frustrating – normal
- Refer to MASH if you see a torn frenum
- Many mechanisms are proposed, including force feeding, twisting and direct blow
- It is a trivial oral injury in dental terms

Prevention :Sleeping - What can I do?

- Teach parents about SAFE SLEEP…particularly regarding the dangers of co-sleeping while under the influence of drugs (legally prescribed or otherwise) or alcohol
- ABC: Alone, on their Back, in a Cot
- Babies aren't good at keeping their temperature constant, so make sure they don't get too hot or too cold
- Keep the room temperature at about 18°C
- Teach parents about bedtime routines

Prevention :Bruising - What can I do?

- Ask questions
- Professional curiosity
- Follow ‘Bruising and injuries to non-mobile children’ policy
- Bruising in a baby who has no independent mobility is very uncommon

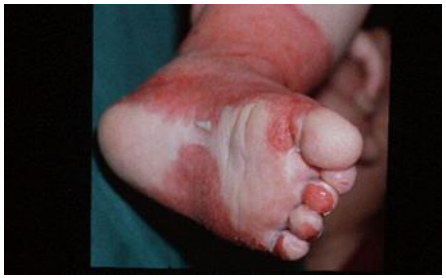


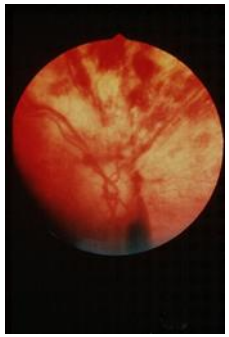
Prevention :Mental health - What can I do?

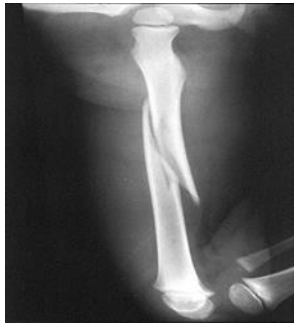
- Ask questions
- Professional curiosity
- Provide advice and support
- Know local services

Prevention: Domestic abuse - What can I do?

- Screen for and address substance abuse, undiagnosed or untreated mental illness in parents/caregivers
- DASH risk assessment
- Know local services eg Splitz

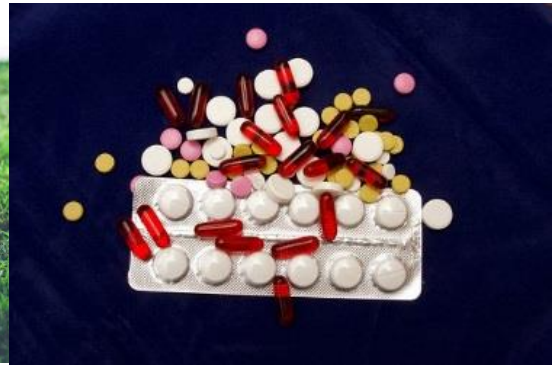






Prevention: Drugs and alcohol - What can I do?

- Ask questions
- Professional curiosity
- Refer to appropriate services



Lessons from local SCRs and Partnership Reviews

- Being sensitive to a baby's needs should be reflected by practitioners seeing the infant and recording/commenting on their presentation, behaviours, relationships and responses with carers
- There is insufficient understanding about the link between adult violence and physical abuse to children, affecting decision-making about risk
- Assessment is a dynamic process: if new information comes to light this may affect the nature and degree of the risk
- A parents' low mood can be an indicator of concern about parenting capacity

Lessons from local SCRs and Partnership Reviews

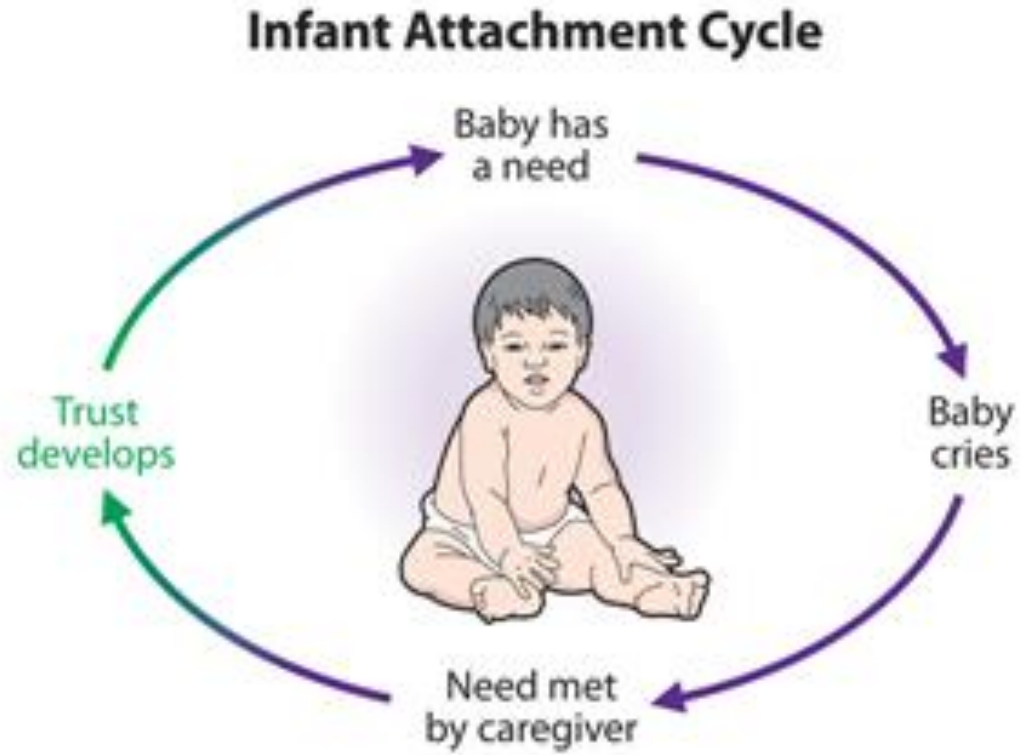
- Children under 1 year old are especially vulnerable, managers should be especially alert to these cases and, where appropriate, challenge what might be fixed thinking
- There is evidence that some professionals do not understand the implications of a bruise/injury to a pre-mobile baby, thus potentially leaving such a child without the protection of urgent CP measures

Take Home Messages

- Under 1's are the most vulnerable group
- Experience tells us that we often fail to recognize early warning signs—and we therefore miss opportunities to intervene and prevent further harm to abused children
- The absence of risk factors is NOT the same as the absence of risk
- Educating caregivers regarding techniques for feeding, soothing a crying infant and the dangers of shaking can be an effective prevention tool

Take Home Message

- Maintain professional curiosity
- Multi-agency information sharing allows for sensible, informed judgements regarding the child's safety to be made
- Bruising in babies is NOT normal
- A bruise should never be interpreted in isolation and must always be assessed in the context of the child's medical, social history, developmental stage and explanation given


Infant Attachment Cycle
Baby has a need
Baby cries
Need met by caregiver
Trust develops