# 7 POINT BRIEFING

## 1 SUMMARY

Wakefield Safeguarding Children Partnership (WSCP) undertook a Rapid Review concerning a 1-year-old who sustained injuries that appeared to be deliberately inflicted. The areas the review considered included the following:

- Effectiveness of cross-border working
- Understanding the risk posed by adults, including men, who have contact with a child
- Use of family history to assess risk and likelihood of harm
- Understanding the lived experience of a child accurately

## 2 WHO WAS THE CHILD AND THEIR FAMILY?

At the time of the incident, the 1-year-old lived at home with their mother, maternal grandmother and maternal uncle. The family have a history with services in Wakefield, the 1-year-old child became known to Wakefield social services in December 2023 following a referral from another local authority.

This referral triggered an assessment by Wakefield Children's Social Care and whilst Child In Need planning had commenced, a domestic incident occurred which determined Child Protection planning was the appropriate course of action. The concerns which required addressing pertained specifically to where the 1-year-old was living in Wakefield and the risks posed by their extended and wider family which included domestic abuse, neglect and the impact of alcohol use by family members. There was no indication of direct physical risk to them during this time or throughout the period of intervention.

Whilst continuing to live in Wakefield, the 1-year-old and mother spent periods visiting an area outside of Wakefield where it is believed their mother was in a relationship with a male. This male appears in records for services in Wakefield. A further male identified after the incident, who was suspected to be in a new relationship with the child's mother, also resided in an area outside of Wakefield in which services locally had no knowledge of until after the incident.

## 3 SUMMARY OF THE INCIDENT

The 1-year-old was brought to a hospital outside of Wakefield by their mother with concerns about conjunctivitis. On examination, they were found to have extensive injuries to several areas of the body.

Further scans identified fractures to both hips and muscle inflammation. The findings indicated the injuries were recent and unlikely to predate the end of Children's Social Care involvement.

## 4 KEY POINTS AND ANALYSIS FROM THE LEARNING CIRCLE

- **The Effectiveness of cross-border working**

**Strong immediate cross-border response:** Out of area hospital contacted Wakefield Children's Social Care directly, enabling swift action**.**
**Clear safeguards on the ward:** Hospital staff implemented immediate protective measures for the 1-year-old.
**Effective police collaboration:** An outside West Yorkshire Police Force and West Yorkshire Police maintained regular communication, supporting both safeguarding and the criminal investigation.
**Health-to-health communication:** Out of area hospital and Mid Yorkshire Teaching Trust worked closely together to share information and coordinate care.

- **Inclusive multi-agency meetings:** Out of Wakefield area services were included in Strategy Meetings, ensuring all relevant agencies contributed to decision-making.
- **Swift safeguarding action:** Wakefield Children's Social Care were able to safeguard the child immediately while supporting a prompt and effective criminal investigation.
- **Need to strengthen cross-border guidance:** The review identified the need to update local guidance so that when a child regularly visits another area, but permanent address remains unchanged, expectations for contacting out-of-area services are clear.

- **Understanding the risk posed by adults, including men, who have contact with a child.**

**Identifying adults in the child's network:** Services recognised multiple adults around the 1-year-old and assessed risks linked to domestic abuse, substance use and individuals posing sexual risk.
**Responding to immediate safety concerns:** Police showed strong practice during an early domestic incident by identifying neglect and physical risk in the home and making a safeguarding referral that led to multi-agency planning.
**Ensuring full information sharing:** Some domestic abuse incidents were not shared across agencies, limiting understanding of cumulative risk. Partners reflected that better information flow would have strengthened professional curiosity and challenge.
**Escalating repeated incidents:** Agencies discussed whether multiple "standard-grade" domestic abuse incidents should trigger higher-level responses, noting that current processes could be improved.

**Monitoring parental relationships:** The father's history of children being removed was shared by another local authority, enabling Wakefield services to monitor contact effectively and maintain clear oversight.
**Understanding significant adults:** Mother's partner featured frequently in records. Although some recording could have been stronger, he was discussed at key meetings and checks showed no known criminality. However, suspected mother's new relationship, services in Wakefield had no knowledge of and did not feature in any service records.
**Considering out-of-area environments:** The child spent time in an area outside of Wakefield for protracted periods, including during the period in which it is suspected the injuries were sustained. Whilst the harm suffered was not foreseeable, services reflected that direct visits and fuller assessment of the area outside of Wakefield context would have strengthened understanding of the environments the child was exposed to.

- **Use of family history to assess risk and likelihood**

**Recognising extensive family history:** The family's long involvement with services was well documented, and practitioners used this information to understand patterns of risk. Exploring domestic abuse at every contact: Midwifery and 0–19 services showed strong practice by routinely creating space for disclosure and discussing risks linked to past and current relationships.
**Understanding parental trauma:** Mother's significant childhood adversity (domestic abuse, conflict, neglect, and alleged intra-familial abuse) was known but could have been used more explicitly to analyse potential impact on the 1-year-old.
**Using assessment tools consistently:** Tools such as HEAT, cumulative risk assessments and the Neglect Toolkit were used well, though earlier use of the Neglect Toolkit may have supported a clearer shared view of risk.
**Balancing trauma with current parenting capacity:** Despite mother's exposure to childhood trauma, records showed she demonstrated warmth, care and responsiveness, and the child was meeting developmental milestones.
**Value of pre-birth assessment:** A pre-birth assessment would have strengthened multi-agency understanding of risk, particularly after a violent incident during pregnancy that was recorded on health and police systems but not submitted as a referral to Children's Social Care.
**Understanding complex family dynamics:** Mother's reliance on her own mother, despite past abuse, suggested a possible trauma bond. Practitioners recognised this complexity while supporting mother to identify when grandmother could be a safe part of the support network.

- **Understanding the lived experience of a child accurately**

**Effective risk management:** Services demonstrated strong assessment and planning to prevent unsafe contact with child's father and to manage risks posed by the wider family.
**Positive multi-agency work:** Practitioners worked well with the mother to improve home conditions and reduce environmental risks, achieving positive engagement and outcomes.
**Following up concerning information:** An overheard conversation about a male visitor pretending to be an "uncle" during a hospital visit highlighted the need for follow-up to understand who adults around the child are.
**Seeing the child directly:** Direct observation of the child at closure showed no injuries and good interaction, reinforcing the importance of seeing, holding, and engaging with the child to understand their lived experience.

## 5 WHAT WILL WSCP DO WITH THESE FINDINGS?

- WSCP Child Safeguarding Practice Review Group (CSPRG) will oversee the learning generated from this review and ensure the following:
- Individual service, Group and System learning points are considered and appropriately attributed to relevant WSCP sub-groups to oversee implementation
- CSPRG adopts all learning points onto its practice review action log to monitor progress of learning and its implementation
- WSCP produces an anonymised 7-point briefing to provide a summary of the incident, key points and analysis and learning points and shares with services alongside holding practitioner briefings

## 6 NEXT STEPS

- The findings of the review have been approved by WSCP, and work is underway in implementing the learning from the incident

## 7 RESOURCES

There are a range of national and local resources, guidance, and training in relation to safeguarding children on the WSCP website.

Wakefield Safeguarding Children Partnership