North Yorkshire Safeguarding Children Partnership

Safeguarding Practice Review - Child AJ

A Case of Maternal Filicide

The purpose of the child safeguarding practice review process, at local and national level, is to identify improvements that can be made to safeguard and promote the welfare of children. They should seek to prevent or reduce the risk of recurrence of similar incidents. They are not conducted to hold individuals, organisations, or agencies to account. Sharing from the learning of these reviews is vital for all practitioners to reflect on to ensure practice is continually evolving in the best interest of children, young people and families.

Introduction

Child AJ was a child with complex needs who was found deceased at home with their mother in July 2025. The mother admitted to administering a fatal overdose of medication to Child AJ and herself. At the time, Child AJ was an open Child in Need case to North Yorkshire's Children and Families Service, with ongoing private law proceedings regarding contact with the father. This case triggered a rapid review to identify learning and improve safeguarding practice across the partnership.

The review highlights multi-agency learning to strengthen safeguarding practice for all children in North Yorkshire.

Context

- Child AJ had a delay in all areas of development.
- The mother was the primary carer and had a history of PTSD and had been a victim of domestic abuse
- The family had extensive involvement with health, social care, and legal agencies, including over 45 health appointments and 12 home visits in 2024.
- Private law proceedings regarding contact with the father were ongoing for over two years, with the first unsupported contact scheduled for the weekend before Child AJ's death.
- "A year prior to the child's death, the mother had reported that if certain circumstances happened, she would have no other option than to kill herself and her child, this is termed a conditional threat

Areas of Good Practice

- **Early Identification and Support:** Health visitors and early years practitioners recognised and responded to Child AJ's developmental needs, making timely referrals and supporting the family with feeding and care plans.
- **Safeguarding Supervision and Oversight:** There was evidence of robust safeguarding structures, including designated safeguarding leads, supervision, and management oversight.
- **Information Sharing:** When the mother disclosed mental health concerns and made the conditional threat, the health staff made referrals to Children's Social Care.
- **Voice of the Child:** Practitioners made efforts to capture the "voice" of Child AJ through observations, despite non-verbal status.
- **Professional Curiosity:** Practitioners explored the family's strengths and challenges, and provided support for both Child AJ's and the mother's needs.

Areas for Development

- **Maternal Filicide Risk:** The risk posed by the mother's conditional threat was not consistently held in mind or managed as circumstances changed, particularly when unsupported contact was granted.
- **Visibility of Risk:** The threat posed by the mother was not clearly documented in case summaries or shared with all relevant professionals, resulting in a loss of focus on this significant risk.
- **Multi-Agency Meetings:** Regular Child in Need meetings were not convened, despite requests, due to the ongoing private law proceedings, resulting in missed opportunities for coordinated information sharing and risk management.
- **Information Sharing and Recording:** Differences in electronic patient and case recording systems, as well as the inconsistent use of safeguarding flags, contributed to gaps in information sharing between agencies and across local authority boundaries.
- **Private Law Proceedings:** The complexity and length of private law proceedings, and the privacy of the family court, limited information sharing, and may have contributed to professional fatigue and loss of focus on earlier risks.
- **Emergency Response:** The initial welfare check was delayed due to process and communication issues between agencies.

Get in touch

To make a safeguarding referral about an adult or child call: 0300 121 3 121

If you have any further questions, or requests for additional resources or training please email us at nyscp@northyorks.gov.uk

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Recommendations (Updates to Actions already completed are in Bold)

- **Maternal Filicide Risk Awareness:** Establish a multi-agency task and finish group to review national learning on maternal filicide and deliver training on risk factors. This should include supporting practitioners to recognise and address both conscious and unconscious bias regarding mothers' capacity to harm their children.
- **Visibility and Management of Non-Urgent Risk:** Agencies to review and strengthen processes for managing conditional threats and non-immediate safeguarding risks, ensuring these are clearly recorded, shared, and revisited as circumstances change.
- **"Important but not urgent":** Training for practitioners to be designed and delivered across the Partnership to encourage the "important but not urgent" management of risk.
- **Consistent Multi-Agency Meetings:** Ensure Child in Need meetings are held at regular intervals for all children meeting the threshold, regardless of private law proceedings, to support coordinated information sharing and risk management.
- **Case Summaries and Information Sharing:** Practitioners and managers to ensure case summaries are up to date and highlight primary risks, and that electronic recording systems support visibility and transfer of safeguarding information.
- **Professional Curiosity and Training:** Promote professional curiosity resources and deliver training on private law, parental responsibility, and information sharing, including the emotional impact of proceedings on parents and children.
- **Enhance Training on Private Law and Parental Responsibility:** Review what training and resources are available for practitioners in respect of private law and parental responsibility, including supporting practitioners to understand what to bring to the court's attention, either in statements or reports, why specific information should be shared and with whom and where they can access legal guidance from when required and guidance on the complexities of private law, parental responsibility, and information sharing during private law proceedings. (Link to YouTube)

Actions and recommendations will be reviewed as part of the NYSCP Practice & Learrning Subgroup meetings

Questions for Reflection

- How can we ensure that conditional threats and non-urgent risks remain visible and are actively managed as circumstances change?
- What systems and processes can be strengthened to support consistent information sharing and recording across agencies and boundaries?
- How do we ensure that multi-agency meetings are held and effective, even during complex or protracted legal proceedings?
- What further steps can be taken to support parent carers of children with complex needs and to recognise and respond to signs of stress, isolation, or risk?
- How can we improve professional curiosity and challenge, particularly in cases where risks may be hidden or minimised?

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What to do now

- Consider the questions for reflection in your team meetings and think about how the learning can be embedded into practice.
- Familiarise yourself with the additional resources and information. and promote across your teams.
- Share your learning and the key messages with your colleagues.

Further partnership Audits and Safeguarding Reviews can be accessed here.

NYSCP learning events can be assessed here:

Pre- recorded learning events can be assessed on the NYSCP YouTube Channel.

Resources & Further Information

All NYSCP practice guidance can be accessed here.

- #AskMe... have the Conversation
- Managing Different Professional Perspectives and Mutual Challenges (Including Professional Resolutions)
- Professional Curiosity
- Information Sharing
- https://www.cafcass.gov.uk/
- Children & Families Practice Guidance - Assessments
- Voice of the Child Practice Guidance & Toolkit

Learning from other Safeguarding Practice Reviews can be accessed here.

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