North Yorkshire Safeguarding Children Partnership

Safeguarding Practice Review - Child AF

The importance of waiting for both parts of the skeletal survey before reducing supervision. October 2025

The purpose of serious child safeguarding case reviews, 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 AF was a 6-week-old baby about whom there were child protection concerns. Child AF had presented several times with different concerns, including bleeding from the mouth, a subconjunctival haemorrhage and a purple mark on their leg. A child protection medical was planned, and parental supervision agreed. However, based on the initial skeletal survey not showing any abnormalities and without discussion with health, the requirement for supervision was removed. The second stage of the skeletal survey revealed 2 rib fractures that were deemed non-accidental. Both parents were arrested, and Child AF and their sibling were removed from parental care.

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

Areas of Good Practice

- The Health Visiting team made multiple attempts to visit the family, and Child AF's mother felt able to disclose health concerns.
- Health Visitors provided tailored advice on safe sleep, ICON, and home safety.
- Monthly GP Liaison Safeguarding meetings enabled information sharing about missed visits, home conditions, and A&E attendance.
- Once a safeguarding referral was made, robust multi-agency procedures were initiated, including timely strategy meetings and child protection medical assessments.
- Information was shared between the Family Assessment and Support Team and the Leaving Care Team, supporting effective relational practice.

Areas for Development

- Pre-Birth Assessments: There were sufficient concerns in the history to warrant a referral to social care when they were still an unborn child, which would have resulted in a pre-birth assessment. Practitioners were working so hard to meet the needs of the adults and the other children in the house that the risk to AF was not fully recognised.
- Skeletal Surveys: Practitioners need to be aware that a skeletal survey cannot be deemed normal until both parts are complete, which takes 14 days
- Professional Curiosity: Multiple unexplained presentations were considered as single issues rather than cumulatively, and guidance on injuries to non-mobile babies was not consistently followed.
- Cumulative Risk: Lack of multi-agency meetings and decision-making resulted in gaps in understanding cumulative risk for both children. Practitioners may have normalised concerns due to high levels of need in the family.

Context

- Child AF's parents were both 22 years old and had experienced significant difficulties as children and young adults, including care experience, mental health, and substance use.
- The family had previous involvement with Children's Social Care, including Child Protection Plans for siblings.
- Multiple agencies were involved, including health, social care, police, and leaving care services.
- The case involved repeated unexplained presentations to health professionals, with missed opportunities for early safeguarding intervention.

Resources & Further Information

All NYSCP practice guidance can be accessed here.

- Day or Night: Sleep Right
- #AskMe... have the Conversation
- Managing Different Professional Perspectives and Mutual Challenges (Including Professional Resolutions)
- Professional Curiosity
- Information Sharing
- Managing Injuries to Non-Independently Mobile Children
- Pre-Birth assessment
- Voice of the Child Practice Guidance & Toolkit

Learning from other Safeguarding Practice Reviews can be accessed here.

Get in touch

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

For further questions, feedback email, **nyscp@northyorks.gov.uk**

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Recommendations

- Pre-Birth Guidance: Review and update NYSCP guidance for safeguarding unborn babies, ensuring pre-birth assessments are considered for children whose older siblings have been subject to a Child Protection Plan.
- Child Protection Medicals: Strengthen practitioner understanding that decisions about supervision and safeguarding should not be made until both stages of the skeletal survey are completed. An agreed statement is now included in paediatric medical reports, and named doctors are embedding this recommendation in their service areas.
- Agreeing on Supervision in Strategy Meetings. Ensure management of risk and supervision is a multi-agency responsibility, with clear conditions for relaxing supervision of children agreed in strategy meetings and review meetings held if there are differences of opinion. Strategy meetings now explicitly record conditions for relaxing supervision, and review meetings are convened as needed.
- Cumulative Risk: Improve multi-agency understanding and assessment of cumulative risk, involving a broad range of specialist services in decision-making.

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

Questions for Reflection

- How regularly and how effectively are other specialist services, for example, GPs, education settings, housing, leaving care teams, domestic abuse, mental health and substance use services involved in multi-agency decision making? What would the benefit to children be of including these services.
- How are we, as a partnership, ensuring effective multiagency information sharing to safeguard children?
- Are safeguarding decisions being made with full information, especially regarding medical investigations?
- How can pre-birth assessments be embedded as routine practice for families with known risks?
- In what ways do our collective approaches to risk identification and management address vulnerabilities such as parental substance misuse, domestic abuse, and environmental factors?
- How do we promote and sustain professional curiosity and challenge across all agencies?
- How do I ensure that when I am supporting parents with multiple vulnerabilities, I don't lose sight of the needs of the child?
- How do we ensure that learning from safeguarding reviews is embedded and sustained in everyday practice?

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.

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