



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 J was a baby who was being investigated for significant feeding difficulties. This included several admissions to hospital. When Child J was 5 months old, they were taken to hospital with a fractured elbow. Further investigations revealed multiple healing fractures inconsistent with the child's developmental stage. The child was not previously known to Children's Social Care. The findings raised significant safeguarding concerns and prompted a multi-agency response. The review focuses on multi-agency learning to strengthen safeguarding practice across North Yorkshire.

**Please note this is being published following the conclusion of ongoing processes.**

## Areas of Good Practice

- Prompt Recognition and Referral:** Health professionals identified injuries inconsistent with the developmental stage and made timely safeguarding referrals.
- Thorough Medical Assessment:** Multiple investigations (X-ray, MRI, skeletal survey) were conducted, leading to the identification of further injuries and faltering growth.
- Open Access and Support:** When Child J was being investigated for feeding difficulties, the family had open access to paediatric services and appropriate follow-ups.
- Routine Enquiry:** Midwives and health visitors made routine enquiries about domestic abuse and maternal mental health.
- Multiagency Response:** Once safeguarding concerns were identified, agencies worked together to safeguard Child J and their sibling, including strategy meetings and medical assessments for both children.

## Areas for Development

- Recognition of Injuries:** Whilst being treated for feeding difficulties, Child J was noted to have both subconjunctival haemorrhage and a blister on the tongue. Each of these should have prompted practitioners to consider and exclude safeguarding concerns (NICE 2017)
- Management of Faltering Growth:** Policies on faltering growth should include the consideration of abuse and neglect.
- Information Sharing:** Gaps were identified in sharing information about maternal mental health and previous domestic abuse between health professionals.
- Review of Records:** Health visitors did not always review previous family records, limiting holistic risk assessment.
- Early Help Coordination:** No consideration was given to single-agency Early Help coordination, which could have supported the family.
- Documentation:** Safeguarding concerns were not always clearly documented, and the rationale for excluding abuse or neglect was sometimes missing.

## Context

- Child J's family had no prior involvement with Children's Social Care.
- The case was identified following hospital admission for unexplained injuries.
- The COVID-19 pandemic impacted the nature and frequency of professional contacts, with restrictions affecting face-to-face assessments and support

## Resources & Further Information

All NYSCP practice guidance can be accessed here.

- [Babies Cry You Can Cope \(ICON\)](#)
- [Managing Injuries to Non-Independently Mobile Children](#)
- [Professional Curiosity](#)
- [Information Sharing](#)
- [Voice of the Child Practice Guidance & Toolkit](#)
- [#Askme - Have the conversation campaign and resources](#)
- [Early Help Guidance](#)

Learning from other Safeguarding Practice Reviews can be accessed here.

## Recommendations (actions are now completed with updates in bold)

- Each organisation is to undertake formal debrief sessions with practitioners involved in this case. **Practitioner debriefs were completed across multiple trusts and primary care, with all involved staff sharing learning and feedback through Serious Incident report discussions and peer reviews. Training packages were updated across health providers, with learning shared through supervision, peer reviews, and group training (including GPs). Safeguarding learning was incorporated into training, including abusive head trauma (ICON education).**
- The two named health trusts are to review their trust policies on the management of faltering growth to ensure the possibility of abuse and neglect is always considered. **Policies on faltering growth were reviewed and updated to ensure safeguarding is considered in such cases, with reliance on NICE guidelines and clear standard operating procedures for frontline practitioners.**
- The named hospital trust is to develop a practice standard for reviewing infants with multiple attendances for feeding problems for possible safeguarding concerns, and share this standard across all relevant health provider organisations. **A standard operating procedure for frequent attenders was developed and shared, with key learning disseminated at partnership conferences.**
- The named hospital trust is to review organisational policies and procedures to ensure relevant health information and significant events are reviewed before new birth visits. **Policies were reviewed, and significant events are now audited monthly via record-keeping audits, with direct feedback to practitioners.**
- The two identified hospital trusts and Primary Care to review information sharing pathways during the antenatal and post-natal period to ensure relevant information about pregnancies and vulnerabilities is shared. **Clear information-sharing pathways were developed and agreed upon by all parties.**
- Awareness of Early Help arrangements (including single agency responses) is to be promoted across health provider organisations. **Early Help frameworks and single-agency responses were promoted across the health economy and highlighted through the Safeguarding Children Health Professionals Network and the NYSCP Threshold Document.**
- The work of the NYSCP Hidden Harm campaign should continue to be promoted across North Yorkshire and the health economy to mitigate the impact of COVID-19. **The Hidden Harm campaign was run across North Yorkshire, with resources shared across all NHS provider organisations.**
- All involved health organisations are to continue developing professional recording practice and standards to ensure NICE guidance ('considered, suspected and excluded') is followed and can be audited. **Health trusts and primary care reviewed documentation policies to ensure NICE guidance is referenced and the 'consider, suspect, exclude' approach is embedded and audited in practice.**

## Questions for Reflection

- How are we, as a partnership, ensuring effective multiagency information sharing to safeguard children?
- How do we ensure that families are given open and safe opportunities to have conversations about the challenges and that messages in relation to safe sleeping, feeding etc, are completed so they encourage conversation, rather than just relaying information.
- In what ways do our collective approaches to risk identification and management address vulnerabilities such as unexplained injuries, faltering growth, and family history?
- How do we promote and sustain professional curiosity and challenge across all agencies?
- What systems are in place to ensure timely assessments and coordinated multiagency responses for children and families?
- 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](#).