North Yorkshire Safeguarding Children Partnership

# Safeguarding Practice Review - Child AH

The importance of including fathers in antenatal and postnatal care. October 2025

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 AH was an 8-week-old, non-mobile baby who was presented to the Emergency Department by their parents with unexplained pain and bruising. Medical investigations revealed multiple fractures at different stages of healing, strongly suggestive of non-accidental injury. Both parents were arrested, and Child AH was placed under an Interim Care Order with the paternal grandmother. The 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.

## Areas of Good Practice

- **Timely Identification and Response:** The NHS 111 call handler made an electronic referral to the Emergency Department, notified the GP, and submitted a safeguarding referral, ensuring safety netting and prompt action.
- **Comprehensive Medical Assessment:** Emergency Department staff fully undressed Child AH, identified bruising, and followed best practice by involving senior clinicians and documenting findings thoroughly.
- **Multi-Agency Coordination:** The Emergency Duty Team convened a strategy meeting, arranged child protection medicals, and coordinated care proceedings swiftly.
- **Consistent Safeguarding Messaging**: Both parents received key safeguarding messages (ICON, safe sleep, domestic abuse) at multiple touchpoints, with understanding checked and reinforced.
- **Information Sharing:** Agencies shared information effectively, with primary care records updated and all relevant professionals informed of safeguarding actions.
- **Routine Enquiry:** Health practitioners made routine enquiries about domestic abuse at appropriate points, and the Trust supported this through training and specialist roles.

## Context

- Child AH was the only child of both parents, living at home prior to the incident.
- Both parents were in paid employment, with no prior safeguarding concerns or known risk factors identified during antenatal or postnatal contacts.
- The family was on the Universal Healthy Child pathway, receiving mandated health visiting contacts.
- The case was managed during a period of ongoing police investigation, with multi-agency involvement from health, social care, and police.

## 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
- 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

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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## Areas for Development

- **Engagement with Fathers:** While the father was included in discussions, there was limited exploration of his mental health and how his dyslexia might affect information processing.
- **Virtual Health Visiting Contacts:** The 6–8 week health visiting contact was virtual, potentially limiting relationship-building and the opportunity for full physical assessment.
- **Parental Disclosure**: Disparities were noted between what parents reported to professionals and what was later disclosed to police, particularly regarding co-sleeping and feeding practices.
- **System Limitations:** The electronic maternity record system did not prompt or record questions about fathers' mental health, and there was a missed opportunity to follow up on a maternal eating disorder history.
- **Access to Support:** Universal pathway families may have limited contact with professionals after mandated visits, potentially reducing opportunities for early help, especially around the peak period for infant crying.
- **IT System Issues:** Parental questions posted to the electronic maternity record were not always seen or responded to by midwives, risking missed opportunities for support.

## Recommendations

- **Enhance Engagement with Fathers and Male Caregivers:** Reiterate the importance of including fathers in antenatal and postnatal assessments and discussions, and ensure practitioners are supported to explore fathers' past experiences and current needs, including any mental health and learning needs.
- **Further Research is Needed on the Effectiveness of Virtual Contacts**: More work is needed to understand the impact of virtual health visiting contacts on relationship-building and safeguarding.
- **Improve System Functionality and Follow-Up:** Address gaps in electronic record systems to ensure both parents' mental health is assessed and parental queries are responded to promptly.
- **Strengthen Early Help and Support Pathways:** Ensure families know how to access support after mandated contacts, particularly during periods of increased risk (e.g., peak infant crying), and promote consistent messaging about available help.
- **Embed Learning from Reviews:** Share learning from this and similar cases across the partnership, reinforce professional curiosity, and ensure all practitioners are aware of updated guidance and support pathways

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

## Questions for Reflection

- How can we ensure fathers and male caregivers are fully engaged and their needs assessed?
- What are the opportunities to evaluate the effectiveness of virtual versus in-person contacts, especially around relationship building and identifying risks that need support
- How do we ensure that both parents' mental health and support needs are identified and addressed?
- How can we better support families to access help during periods of increased risk, such as the peak period for infant crying?
- 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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