North Yorkshire
Safeguarding Children Partnership

Safeguarding Practice Review - Child AC

Highlighting the need for clear communication channels when children in care proceedings are inpatients for a period of time. 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 AC was a baby, born prematurely at 24 weeks in hospital, who sadly died there at three months old after developing medical complications of prematurity. At the time of death, AC was subject to an Interim Care Order with Care Planning Regulations for Placement with Parent.

The circumstances of AC's death led to a rapid review by the North Yorkshire Safeguarding Children Partnership (NYSCP) to identify learning and improve safeguarding practice across the partnership.

Context

- AC's mother had a history of complex trauma, mental health difficulties (including Post Traumatic Stress Disorder, Autism, Attention Deficit Hyperactivity Disorder, and Emotionally Unstable Personality Disorder), and substance use.
- AC's father was known to police for multiple domestic abuse and child abuse incidents in which he was the suspect. The parents were not in a relationship but intended to co-parent.
- Child AC's mother promptly informed her GP of her unplanned pregnancy at around 5–6 weeks of gestation, engaged with antenatal care services, consistently sought medical advice, and attended all scheduled appointments.
- Two older siblings had previously been removed from mother's care due to concerns about neglect, substance use, domestic abuse, and poor home conditions.
- Both parents were observed to provide good care to AC while on the neonatal unit
- Multiple agencies were involved in supporting the family, including Children's Social Care, Police, Healthy Child Service, Mental Health Services, Substance Use Service, and Primary Care.

Areas of Good Practice

- Mother's mental health needs were considered, and appropriate support was offered during pregnancy, and continued to be provided after AC's death.
- The home environment was assessed by multiple services working with the family, and was found to be improved compared to previous years.
- Good record-keeping and triangulation of historical risks with current safeguarding needs.
- Effective information sharing between primary care, midwifery, and social care.
- The Specialist Mother and Baby Service mental health team identified and communicated safeguarding concerns.
- The Neonatal Team sought advice and supervision from the Children's Safeguarding Team.
- A risk plan was in place regarding parental involvement, agreed when the Interim Care Order was made

Get in touch

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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

- Increase communication and sharing of assessments between agencies.
- Lack of understanding of roles and responsibilities with the acute trust for the robust recording and sharing of incidents where parents appeared intoxicated or abusive on the ward.
- Lack of clarity regarding which hospital staff should be provided with information relating to care proceedings and child protection processes led to insufficient information sharing between Children's Social Care and the neonatal unit.
- Challenges in parents' access to appropriate mental health services, with inappropriate referrals and delays.
- Unclear if adaptations to communication for mothers' neurodiversity and trauma were widely understood and implemented.
- Need for better understanding and use of assertive outreach for adults with complex needs, with the onus on the service to engage the service user.
- The children's workforce to have a good understanding of the pathways into adult safeguarding services.

Recommendations

- The identified key themes and best practice will be summarised in a briefing paper that will be published on the North Yorkshire Safeguarding Children Partnership website, Learning for Professionals page, this paper is the output from this recommendation.
- Those present at the review will ensure the key learning points are shared with relevant practitioners involved in the care of AC in their organisations.
- Specialist Mother and Baby Service Mental Health to review barriers to direct communication with Children's Social Care and consider transferable best practices.
- Services to explore assertive outreach approaches for adults with complex needs.
- The adult drug and alcohol service to ensure all pregnant individuals are allocated appropriately trained workers and flagged at daily meetings.
- Acute Trust to review record-keeping and information sharing, especially regarding parental behaviour when not patients.
- Children's Social Care and the acute trust to clarify information sharing during child protection and/or court proceedings.
- NYSCP Practice and Learning sub-group to communicate thresholds and pathways for adult safeguarding referrals.
- NYSCP to promote best practice in working with neurodiverse and trauma-affected parents.
- Further promotion of the #AskMe...Have the Conversation campaign to encourage tailored, two-way discussions with parents about risk factors such as smoking.

Recommendations to be reviewed through the NYSCP Practice & Learning Subgroup

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Questions for Reflection

- How do we ensure that information about parental risk factors is shared promptly and directly between all relevant agencies? How are we assured that this has been done? Reflect on good practice from this review or work completed locally.
- Are we adapting our communication and support for parents with neurodiversity or trauma histories? How can we do this?
- What do we need to improve assertive outreach to engage adults with complex needs in safeguarding processes?
- What steps can we take to ensure fathers' identities and involvement are accurately recorded and considered in assessments?
- How do we ensure that learning from rapid reviews is embedded in everyday practice across all agencies?
- How can we improve professional curiosity and challenge, particularly in cases where risks may be hidden or minimised?

What to do now

- Familiarise yourself with the NYSCP guidance and resources.
- Share the learning from this review with your team and discuss how it applies to your practice.
- Attend or arrange learning sessions on multi-agency information sharing, working with neurodiverse parents, and assertive outreach.
- Promote and participate in the #AskMe... Have the Conversation campaign.
- Reflect on your own team's processes using the questions above and identify areas for improvement.
- Ensure that any new or updated guidance is disseminated and understood within your service.

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
- Children & Families Practice Guidance - Assessments
- Voice of the Child Practice Guidance & Toolkit

Learning from other Safeguarding Practice Reviews can be accessed here.

Other Useful Information: The Myth of Invisible Men Summary