North Yorkshire Safeguarding Children Partnership

Safeguarding Practice Review - Child L

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 L was a 27-day-old baby found in a life-threatening condition with their mother in North Yorkshire in April 2021. The child had multiple injuries, was severely unwell, and amphetamines were detected in their urine. Mother A, with a history of puerperal (post-partum) psychosis, was detained under the Mental Health Act. Siblings were placed with their father. Child L was placed in foster care.

The case was subject to a Rapid Review and a Local Child Safeguarding Practice Review (LCSPR) due to its complexity and significant multi-agency involvement. The police investigation has now concluded with no further action. The case has resulted in substantial learning and updates to local safeguarding practice.

The report was compiled in October 2025 following the completion of the police enquiry.

Please note that publication of the briefing has been delayed due to criminal proceedings. Actions have been reviewed as part of the NYSCP Practice & Learning Subgroup

Areas of Good Practice

- **Prompt multi-agency response:** Agencies responded quickly to the incident, with police, ambulance, and hospital staff working together to ensure Child L received urgent medical care and safeguarding intervention.
- **Effective escalation and referral:** The case saw timely escalation from Early Help to Children's Social Care when concerns about Mother A's mental health and engagement increased. Referrals were made by health, social care, and education professionals, demonstrating awareness of thresholds and willingness to act. Professional curiosity and persistence: School staff and health visitors demonstrated professional curiosity, making repeated attempts to engage with Mother A and the wider family, and raising concerns when information was inconsistent or when engagement was poor
- **Multi-agency information sharing: T**he rapid review process itself was thorough, with detailed chronologies and contributions from all involved agencies, enabling a comprehensive understanding of the case and identification of learning points.
- **Use of safeguarding tools and meetings:** The Multi-Agency Screening Team (MAST) was utilised to screen referrals and coordinate responses. Strategy meetings and Child in Need meetings were convened to share information and plan support for the family.
- **Learning from previous incidents:** Agencies referenced and built upon learning from earlier safeguarding reviews and serious incidents involving the family, demonstrating a commitment to continuous improvement.

Areas for Development

- Cumulative risk assessments were not always completed or shared; not all professionals fully understood the 50% risk of relapse in mothers with previous puerperal psychosis.
- Safety plans were not always robustly multi-agency or consistently monitored.
- There was over-reliance on the mother appearing "well" and on the maternal grandmother as a protective factor, despite limited information sharing.
- Some agencies worked in silos; escalation procedures were not always followed when concerns persisted or when professionals disagreed.
- The wider family network was not fully explored or utilised as a protective factor.
- Not all relevant professionals were always able to attend Child in Need meetings; partnership responsibility for proactive engagement remains.

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 (actions are now completed with updates in bold)

- **Formal Welfare Debrief:** All practitioners involved in the case should receive a structured debrief to support wellbeing and share learning. **Full debrief delivered, including reflection on recommendations and practice improvements.**
- **Cumulative Risk Assessment:** Mental Health Trusts must ensure risk assessments consider historic and current factors and are shared across agencies. **Tees Esk & Wear Valley reviewed and embedded cumulative risk assessment processes.**
- **Information Sharing:** Strengthen communication between mental health, midwifery, and local authority services, ensuring complex information is explained in plain English. **Level 3 safeguarding training now includes this; regular multi-agency teaching sessions are delivered.**
- **Timeliness of Step-Across Meetings:** Improve speed and clarity when moving cases from Early Help to Child in Need. **Audits confirm timely step-across meetings; no current issues identified.**
- **Multi-Agency Meeting Attendance:** Ensure all relevant professionals are invited and able to contribute to Child in Need processes. **Invitations issued consistently; partnership responsibility reinforced to secure attendance.**
- **Pre-Birth Guidance:** Develop and publish multi-agency guidance for cases involving previous puerperal psychosis or prior child protection concerns. **Guidance available on the NYSCP website.**
- **Escalation Procedures:** All Designated Safeguarding Leads must provide assurance that staff know how to escalate concerns appropriately. **Escalation guidance was published and promoted via the NYSCP website.**
- **MAST Screening:** NYSCP to assure robust multi-agency screening of referrals, including timely identification of all relevant agencies. **MAST processes audited regularly; thresholds reviewed as part of audits.**
- **Family Network Engagement:** Emphasise the importance of working with family networks to increase safety and manage risk. **Strength in Relationships guidance is promoted and available online.**
- **Data Review on Puerperal Psychosis Cases:** Explore feasibility of identifying cases with previous harm or child protection involvement for professional review. **Recommendation deemed not SMART; data not achievable.**

Questions for Reflection

- How confident are you that all staff in your agency understand the risks associated with parental mental health, especially puerperal psychosis?
- Are cumulative risk assessments routinely completed and shared in your service?
- How do you ensure that safety plans are genuinely multi-agency and robustly monitored?
- What mechanisms are in place to challenge or escalate concerns if you disagree with another agency's assessment or plan?
- How do you ensure that the wider family network is considered and engaged in safety planning?
- Are all relevant professionals consistently invited and enabled to contribute to Child in Need and safeguarding meetings?

Resources & Further Information

All NYSCP practice guidance can be accessed here.

- Strengths in Relationships Practice Model
- Managing Different Professional Perspectives and Mutual Challenge (including Professional Resolution Guidance)
- Information Sharing
- Framework for Decision Making: Right help, at the right time by the right person
- Children of Parents with Mental Health Problems
- Pre-Birth
- Safeguarding unborn babies
- Parental Mental Ill Health on Children

Learning from other Safeguarding Practice Reviews can be accessed here.

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