North Yorkshire Safeguarding Children Partnership

Safeguarding Practice Review - Child AI 2026

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

This Safeguarding Practice Review was commissioned following an incident in which Child AI, a very young child, was admitted to hospital with multiple injuries that were assessed as non-accidental. At the time of the incident, Child AI was already known to statutory services and subject to a child protection plan, alongside older siblings with a history of safeguarding involvement.

The review examined how agencies worked together to safeguard Child AI over time, including how concerns were identified, assessed and responded to across the child's early life. Particular attention was given to decision-making in the context of long-standing family involvement, multiple adult vulnerabilities and changing caregiving arrangements, to identify learning that could reduce the risk of similar harm occurring in the future.

Context

Child AI was known to safeguarding services from pre-birth, alongside older siblings who had previously been subject to child protection intervention. The family were supported by multiple agencies over time due to concerns including neglect, parental mental health difficulties, domestic abuse and unsafe adult relationships. The family context was complex and included several significant adult relationships. The children had different fathers, and there were changes over time in who was providing day-to-day care. Both Child AI's father and the fathers of the older siblings had their own histories of trauma, mental health needs and previous involvement with services. New adult relationships were formed during periods of statutory involvement, adding further complexity to risk assessment, safety planning and information sharing. The review highlights that while individual incidents were responded to, it was not always clear how the accumulation of concerns over time, combined with changing family relationships and caregiving arrangements, was fully recognised and reflected in multi-agency decision-making and planning.

Areas of Good Practice

Early identification of risk and robust pre-birth safeguarding planning.

- Routine enquiry and home environment assessments used consistently.
- Multi-agency working through strategy meetings, core groups and GP liaison.
- Clear focus on infant safety, including safe sleep and coping with crying messages.
- Evidence of professional challenge at key decision points.
- Inclusive practice that involved fathers and male carers in safeguarding discussions.

Resources & Further Information

- Working Together to Safeguard Children (2023)
- NYSCP pre-birth assessment guidance
- ICON: Coping with Crying
- NICE guidance on perinatal mental health and safeguarding.

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

North Yorkshire
Safeguarding Children Partnership

- Inconsistent information sharing and unclear provenance of key information.
- Limited recognition and recording of cumulative risk and harm over time.
- Safety plans not always adapted to adult vulnerabilities or changing circumstances.
- Insufficient professional curiosity about adults' histories, relationships and networks.
- Poor clarity in recording decision-making, risk assessment and plan changes.

Recommendations

- Strategy meetings should be convened with sufficient preparation time and the right professionals present, ensuring a shared understanding of risk and strength.
- For complex cases, multi-agency reflective supervision should be standard practice, including at points of transfer.
- Practitioners should consistently use clear family trees and genograms to understand relationships and risk.
- The impact of parental mental health, physical health or neurodivergence on parenting capacity should be clearly addressed within plans, with reasonable adjustments where required.
- All agencies must consistently recognise, assess and record cumulative risk and harm, reflected in chronologies, case summaries and supervision.
- Practitioner understanding of child sexual abuse medical pathways and referral processes should be strengthened.

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

Questions for Reflection

1• How confident are you that all relevant information is shared before key decisions are made?
• How do you identify and respond to cumulative risk in long-standing cases?
• Are safety plans realistic and responsive to adult needs and capacities?
• How do you maintain professional curiosity when families are well known to services?
• Is your recording clear enough for another practitioner to understand risk and rationale?

What to do now

Reflect on cases where cumulative risk may be developing over time.
• Review safety plans to ensure they reflect current risks and adult needs.
• Use supervision to explore uncertainty, alternative hypotheses and challenge.
• Ensure decisions and their rationale are clearly recorded and shared.

Get in touch

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

If you have any further questions, email us at **nyscp@northyorks.gov.uk**