

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 AK, a young child who was known to a range of agencies over several years. Child AK was born in 2020 and was one of five children living in a family experiencing long-standing and complex adversity, including parental trauma, domestic abuse, substance misuse, housing instability and siblings with additional needs. From infancy, Child AK experienced feeding difficulties, developmental delay and increasing vulnerability. In 2025, Child AK was admitted to the hospital with significant malnutrition, frailty and evidence of cumulative neglect, prompting serious safeguarding concerns.

The review considered how agencies understood and responded to Child AK's needs over time, including how information was shared, risks were assessed, and decisions were made in the context of a complex family environment. The learning from this case highlights important considerations for practice when working with young children experiencing chronic vulnerability.

Areas of Good Practice

- **Schools** worked well together and demonstrated strong professional curiosity, practical support and consistent concern for children's day-to-day well-being.
- **Police practice** improved over time, with clearer and more detailed recording of home conditions and child presentation.
- **Health visiting services** responded promptly and robustly when concerns escalated, coordinating referrals and escalation effectively.
- There were examples of **effective information sharing and handover** between services when children moved between areas.

Resources & Further Information

- [Professional Curiosity](#)
- [Managing different professional perspectives](#)
- [Neglect](#)
- [Best Start in Life health advice - NHS](#)
- [Voice of the child toolkit](#)



Context

- Child AK lived within a large family with several siblings whom had identified neurodevelopmental and additional needs, placing sustained pressure on parental capacity.
- The family context included parental trauma, mental health difficulties, domestic abuse, substance misuse and housing instability.
- Extended family members provided intermittent care; however, these arrangements were often informal, short-term and themselves under strain.
- The family moved repeatedly across multiple local authority areas, disrupting continuity of professional oversight and access to health and developmental services.
- Professional attention was frequently drawn to acute adult crises or the more visible needs of older siblings, increasing the risk that younger or quieter children, including Child AK, were less visible within assessments and decision-making.

Areas for Development

- **Recognition of cumulative harm:** Concerns were sometimes viewed in isolation rather than as a pattern over time.
- **Equal visibility of all children:** Child AK's needs were at times overshadowed by sibling crises and adult vulnerabilities.
- **Developmental understanding:** Some presentations were accepted without sufficient challenge against developmental expectations.
- **Safety-netting and follow-through:** Actions were sometimes left with parents without clear timescales or escalation plans with coordinated support from partners.
- **Early Help:** Involvement was occasionally interpreted as evidence of reduced risk without sufficient multi-agency triangulation.

Recommendations

- Recognise cumulative risk:** Partners must assess concerns as patterns over time, not isolated incidents, using chronologies and shared information to understand cumulative harm.
- **Ensure every child is seen:** Assessments and decisions must clearly reflect the lived experience of each child, particularly younger, quieter or non-verbal children.
 - **Strengthen professional curiosity:** Practitioners should question whether behaviour is developmentally expected and avoid relying on single explanations or parental narrative alone.
 - **Embed clear safety-netting:** When actions are left with parents, professionals must set clear expectations, timescales, and follow-up, with clear partnership plans on who is best suited to support parents with any barriers, with clear escalation and contingency if actions are not completed.
 - **Use Early Help appropriately:** Early Help should not be viewed as evidence that risk has reduced without multi-agency triangulation of impact for the child.
 - **Support challenge and escalation:** Partners should feel confident to challenge decisions, including where parental engagement may be masking ongoing harm.

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

Questions for Reflection

- **How do we ensure cumulative harm is recognised, not normalised?**
- **Are quieter or non-verbal children being seen and understood?**
- **Do we rely too heavily on parental engagement as evidence of capacity?**
- **How are we working together with partners to address any barriers to engagement or to support parents with actions?**
- **Are step-down decisions informed by up-to-date information about all children?**
- **How confident are we to challenge when something does not feel right?**

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 audits and learning can be accessed [here](#).