North Yorkshire Safeguarding Children Partnership

Safeguarding Practice Review - Child AL 2026

Domestic Violence Disclosure Scheme (DVDS)

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 AL, is a 25 day old child, who sustained serious injuries in December 2025 that were assessed as highly suggestive of non-accidental harm. The purpose of the review is not to apportion blame or reinvestigate the incident, but to identify learning to strengthen safeguarding practice, systems, and partnership working; particularly in relation to very young children.

The review focused on the Domestic Violence Disclosure Scheme (DVDS), including the "Right to Ask" and "Right to Know", alongside professional curiosity, information sharing, cumulative risk and understanding of agency roles. The review highlighted the complexity of safeguarding where agencies followed expected processes but did not develop a shared understanding of historic risk.

Context

The child was born in late November 2025 and lived with both parents and an older sibling. The family moved across local authority and health boundaries during the child's short life, receiving routine maternity and early years support.

At 25 days old, the child sustained serious injuries at home, resulting in hospital admission, safeguarding intervention, and a police investigation. A key contextual factor is that the father had a significant history of domestic abuse, including custodial sentences and MARAC involvement.

Information relating to the father's previous offending history was known within parts of the system but had not contributed to a shared understanding of risk across agencies.
The review considered how historic domestic abuse information is recognised, shared and used to safeguard babies and young children, and the extent to which DVDS, professional curiosity and multi-agency information sharing support preventative safeguarding.

Areas of Good Practice

The review identified several areas of effective practice.

- Routine enquiry regarding domestic abuse was undertaken, and opportunities were provided for the mother to speak away from the father.
- Agencies demonstrated a clear understanding of their statutory roles and responsibilities.
- Police practice of notifying maternity services where domestic abuse incidents involve a pregnant woman was highlighted as positive preventative practice.
- Medical assessment and safeguarding responses following presentation at hospital were timely and robust, including child protection medical assessment and multi-agency coordination.
- Partners engaged openly and reflectively throughout the review process, contributing to a richer understanding of the complexities involved.

These strengths demonstrate strong reactive safeguarding practice once risk became visible.

Resources & Further Information

- Working Together to Safeguard Children 2026
- Domestic Violence Disclosure Scheme factsheet
- The Myth of Invisible Men
- NYSCP DVDS Clare's Law
- NYSCP - MARAC & MATAC Domestic Abuse Meetings
- NYSCP - Pre-Birth Assessments
- NYSCP - Professional Curiosity
- Domestic abuse practice guidance/

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

Understanding DVDS in Safeguarding Practice
The review found that agencies had a good procedural understanding of the Domestic Violence Disclosure Scheme. However, the discussion highlighted the importance of increasing partnership understanding of how DVDS may be considered alongside safeguarding processes, particularly during pre-birth and early years work. The review recognised that "Right to Know" disclosures are dependent on identified triggers and that no such triggers existed in this case.

Professional Curiosity and Fathers
The review identified that professional curiosity was evident, but that questioning alone did not create a fuller understanding of risk. The discussion highlighted the importance of exploring, interpreting and sharing information about fathers and male carers, including historic behaviour and previous relationships.

Cumulative Risk and Information Sharing
Information existed across agencies, but did not translate into a shared understanding of risk. The review highlighted the difficulty of building a cumulative picture of risk when information is historic, held across different organisations or areas, and not linked to current safeguarding incidents.

Understanding Agency Roles and Probation Processes
Partners reflected that assumptions were made about ongoing probation involvement following release from custody. The review highlighted the need for stronger multi-agency understanding of probation responsibilities, end-of-sentence arrangements and circumstances where statutory involvement ceases.

Moving Beyond Process Compliance
The review concluded that this case does not represent a failure of process. Rather, it illustrates the limits of process-driven safeguarding and the challenge of translating historic information into preventative safeguarding action when there are no clear triggers for intervention.

Recommendations

- Strengthen partnership understanding of the Domestic Violence Disclosure Scheme (DVDS), including the "Right to Ask" and "Right to Know", within pre-birth and early years safeguarding, particularly where relationships are new and professional knowledge of family circumstances is limited.
- Share learning from this review across the partnership to support understanding of how professional curiosity, information sharing and cumulative risk operate in complex safeguarding situations.
- Promote understanding of cumulative risk and strengthen multi-agency approaches to building a shared understanding of risk across organisational and geographical boundaries.
- Increase partnership understanding of probation roles, responsibilities and end-of-sentence arrangements to reduce false assumptions about ongoing statutory oversight.

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

Questions for Reflection

Domestic Abuse Disclosure Scheme (DVDS)
- How confident are we in understanding the difference between "Right to Ask" and "Right to Know"?
- When discussing families during pregnancy or infancy, how do we consider whether DVDS could support safeguarding activity?
- Are we clear about the triggers required for a "Right to Know" disclosure?

Professional Curiosity
- How do we ensure curiosity moves beyond asking questions to developing a shared understanding of risk?
- To what extent do we explore the history of fathers and male carers, including previous relationships?

Cumulative Risk
- How do we capture and share historic information that may be relevant to current safeguarding?
- How do we respond when there are gaps in information or limited knowledge of a family's history?

Agency Roles
- Do we fully understand the role and remit of partner agencies, including probation services?
- How do we challenge assumptions about ongoing agency involvement?

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