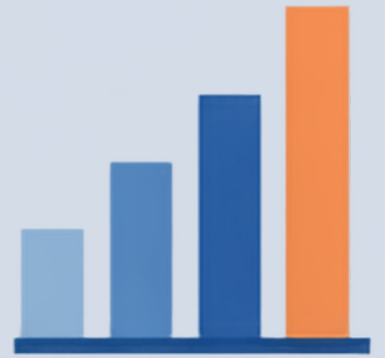




Child Death Overview Panel Annual Report

2025 - 2026



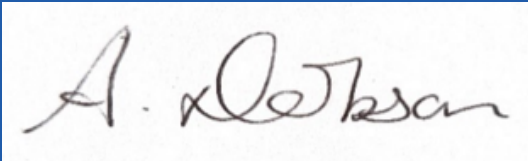
Child Death Overview Panel Annual Report 2025 - 2026

Foreword

Over the past year, the City of York and North Yorkshire Child Death Overview Panel has continued to demonstrate the value of effective multi-agency collaboration in understanding why children die and identifying opportunities to prevent future deaths. The learning generated through our reviews has informed local and regional initiatives, strengthened professional practice and contributed to system-wide improvements across partner organisations.

I am particularly proud of the commitment shown by panel members during a period of sustained demand and pressure across health, social care and safeguarding services. Despite these challenges, members have consistently brought their expertise, professionalism and compassion to the review process, ensuring that every child death is considered with care and sensitivity.

Our collective ambition remains clear: to learn from every child's death, support families with dignity and respect, and use that learning to improve the safety, health and wellbeing of children and young people across North Yorkshire and the City of York. Through continued partnership working, we remain committed to making a positive difference for children, families and communities.



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Chair, Child Death Overview Panel (CDOP)
[North Yorkshire & York Child Death Overview Panel]



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Introduction

The death of a child is one of the most devastating experiences a family, community and professional network can face. For parents and carers, it represents an immeasurable loss; for siblings, extended family and friends, it is life-altering; and for professionals involved with the child and family, it is a moment that demands reflection, compassion and learning.

At the heart of the Child Death Review process is a commitment to understand how and why children die, to learn from every death, and to use that learning to help reduce the risk of future child deaths wherever possible. This work must be undertaken with sensitivity, respect and without blame, recognising both the profound impact of bereavement and the complexities often present in families' lives.

The Child Death Review process is carried out in line with national statutory guidance set out in Working Together to Safeguard Children (2026) and the Child Death Review Statutory and Operational Guidance (2018). North Yorkshire and City of York Local Authorities have worked together since 2008 to review the deaths of children to ensure that the arrangements are robust and effective in order to support shared learning, consistency in practice and a coordinated response to safeguarding and prevention.

The Child Death Review process operates on the principle that learning from child deaths should contribute to continuous improvement in safeguarding, health and wellbeing. This includes identifying strengths in professional practice as well as areas where systems, services or support could be strengthened.

Throughout the process, the voices and experiences of families are treated with care and respect. While families do not attend professional meetings, their voices and lived experiences are captured through those professionals working with the family to inform learning. The aim is not only to prevent future deaths, but to ensure that families are supported with dignity and compassion following the death of a child.

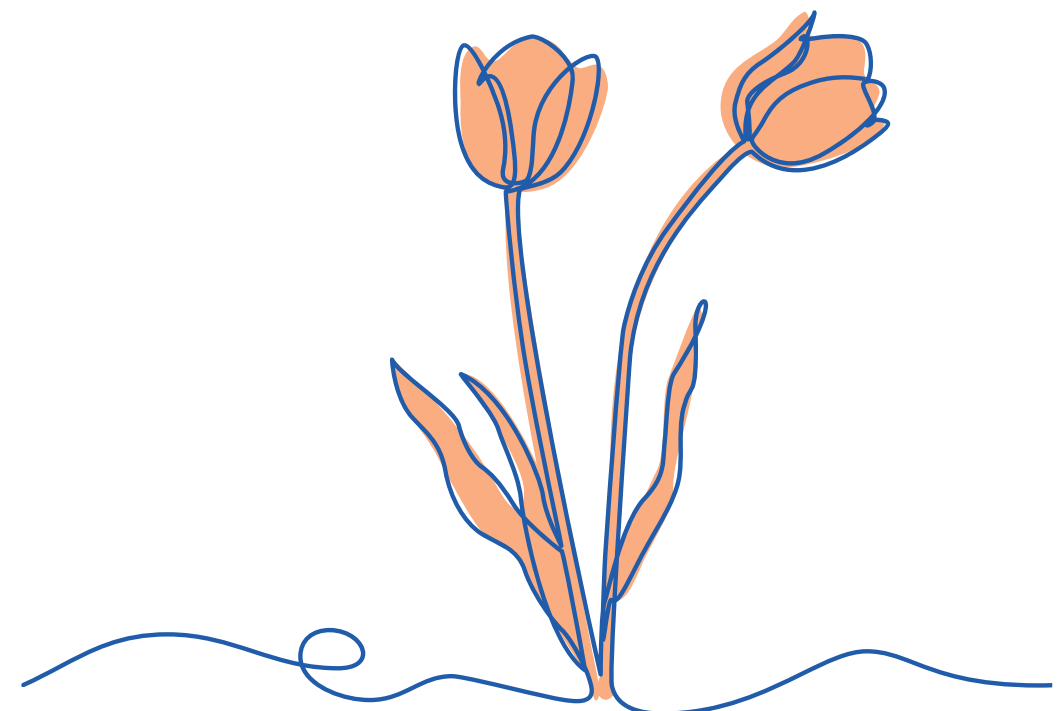
Child deaths rarely result from a single factor. They often occur within a wider context of health, environmental, social and systemic influences. Understanding these complexities requires strong multi-agency working, professional curiosity and shared responsibility across organisations.



Through the combined work of the Child Death Overview Panel, the Strategic Child Death Review Group and Safeguarding Children Partnerships, learning from child deaths is used to inform:

- Prevention and public health initiatives
- Professional training and guidance
- Priority areas for the Child Death Panel and partners
- System-wide improvement

This report reflects our shared commitment to learning, prevention and collaboration, with the ultimate aim of improving outcomes for children and families across North Yorkshire and the City of York.



North Yorkshire and City of York Child Death Overview Panel

The Child Death Overview Panel (CDOP) is a statutory, multi-agency forum responsible for reviewing the deaths of all children normally resident in North Yorkshire and the City of York, as well as non-resident children who die within the local area.

The Panel's primary purpose is to understand how and why children die, to identify learning, and to determine whether there are opportunities to reduce the risk of future deaths through changes to practice, systems or public health approaches.

While Child Death Overview Process operates within a national statutory framework, its work is firmly rooted in the local context, reflecting the needs of children, young people and families across local areas.

The Panel meets on a regular basis to review anonymised cases once all relevant information has been gathered from agencies involved with the child and family. This includes information from health, children's social care, police, education and other relevant partners.

- Each child is considered carefully to:
- Confirm or clarify the cause of death.
 - Identify contributory and modifiable factors.
 - Recognise examples of effective practice.
 - Agree learning points and recommendations.

Panel discussions are informed by professional expertise from a range of disciplines and focus on learning rather than blame, ensuring a respectful and reflective approach.

The Child Death Overview Panel comprises of senior representatives from statutory and non-statutory agencies, bringing together a broad range of professional expertise. Membership reflects the statutory requirements of the Child Death Review process and ensures that discussions are informed by safeguarding, public health, clinical and commissioning perspectives.

- Members attend and are expected to:
- Contribute objective, professional oversight.
 - Challenge appropriately and constructively.
 - Remain focused on learning and prevention.



FROM REVIEW TO SYSTEM IMPROVEMENT

How CDOP learning is shared, governed and translated into action

Multi-agency insight enables the Panel to identify system-wide themes, influence change across organisations and strengthen prevention.

LEARNING THAT LEADS TO ACTION

1

SHARE

Key themes, risks and recommendations are shared with safeguarding partnerships.

2

ALERT

Specific issues can be reported to the National Child Mortality Database for immediate national alert and action.

3

INFORM

Learning informs training, guidance, communications and public health prevention priorities.

4

RESPOND

Concerns about abuse, neglect or professional practice trigger appropriate notifications and safeguarding processes.

G

CLEAR GOVERNANCE AND ACCOUNTABILITY

Oversight is provided by the Strategic Child Death Review Group for North Yorkshire and the City of York.

- Learning is understood at a senior strategic level.
- It is linked to wider safeguarding and public health priorities.
- It is translated into meaningful system improvement.

FAMILIES AT THE HEART

Every review begins with a bereaved family.

Families do not attend CDOP meetings, but their experiences, questions and perspectives are represented through the review process and the allocated key worker.

The process must be compassionate, sensitive, respectful and focused on dignity and care.

SUPPORTING ALL THOSE AFFECTED

A child's death can have a profound and far-reaching impact.

CDOP recognises the emotional, psychological and professional impact on staff, members of the public and communities.

Compassionate communication, wellbeing support, reflective practice and opportunities for debriefing help foster resilience.

OUR COMMITMENT

COMPASSION
Trauma-informed practice

CURIOSITY
Robust analysis

COLLABORATION
Partnership working

PREVENTION
Learning to keep children safe

Through reflective review and partnership working, the Panel honours the lives of children who have died by learning from their deaths and working collectively to reduce risk for others.

Who Are We

CHILD DEATH OVERVIEW PANEL

Supporting those affected | Learning together | Reducing risk



RECOGNISING THE IMPACT

The death of a child has a profound and far-reaching impact on families, professionals and communities. CDOP recognises the emotional, psychological and professional challenges experienced by all those involved.

OUR COMMITMENT A culture of compassion, reflection and support

01

COMPASSION

Recognising the impact

02

SUPPORT

Wellbeing and debriefing

03

REFLECTION

Shared learning

04

PARTNERSHIP

Working together

05

RESILIENCE

Strengthening wellbeing

WHO WE ARE Senior representatives from across North Yorkshire and the City of York

1

HEALTH & PUBLIC HEALTH

Public health, designated doctors, named nurses, safeguarding teams and healthy child services

2

MATERNITY SERVICES

Senior midwifery representatives from local NHS trusts

3

POLICE

Safeguarding leadership and detective representation

4

CHILDREN'S SOCIAL CARE & SAFEGUARDING

Social care managers, safeguarding partnership managers and the Child Death Review Officer

5

EDUCATION, INCLUSION & EARLY HELP

Senior representatives from inclusion and early help services

OUR SHARED PURPOSE

Through reflective review and partnership working, we honour the lives of children who have died by learning from their deaths and working collectively to reduce risk for others.

Joint Agency Response Meeting (JARM) and Key Worker Role

When a child dies unexpectedly, a Joint Agency Response Meeting (JARM) will be convened within 72 hours of the death. The purpose of the Joint Agency Response Meeting is to enable effective information sharing, facilitate multi-agency discussion, and ensure that any immediate safeguarding concerns are identified and addressed.

Supporting and engaging with families who have lost a child is of paramount importance throughout the Child Death Review process. This support must recognise both the complexity of the process and the varied emotional responses associated with bereavement.

In North Yorkshire and York, the JARM will identify the most appropriate agency to provide support to the bereaved family. This support role is defined locally as the "Key Worker."

The Key Worker should:

- Act as a reliable and accessible single point of contact for the family following the child's death.
- Coordinate communication and meetings between the family and professionals, as required.
- Provide clear information about the Child Death Review process and any ongoing investigations relating to the child.
- Liaise, where appropriate, with the Coroner's Office and the Police Family Liaison Officer (if involved).
- Represent the voice of the parents in professional meetings, ensuring their questions are raised and addressed, and provide feedback to the family afterwards.
- Signpost families to specialist bereavement support services where needed.

Although parents do not attend Child Death Review meetings, they will be given opportunities, through the Key Worker, to:

- Contribute information, comments, or questions to those meetings.
- Receive feedback from discussions, ensuring they remain informed and involved.

The Key Worker therefore acts as the conduit between the family and Child Death Review partners, ensuring effective communication and meaningful parental involvement.

In addition, all bereaved parents will be provided with the nationally produced guide, "When a Child Dies," to support their understanding of the process.



Child Death Review Meeting

All child deaths, whether expected or unexpected, must undergo a Child Death Review Meeting (CDRM).

The Child Death Review Meeting is a multi-agency meeting where professionals who were directly involved in the care of the child during their life come together to review all relevant information relating to the child's death. The purpose of the meeting is to develop a comprehensive understanding of the circumstances surrounding the death and to identify any learning that may help prevent future deaths.

The Child Death Review Meeting will normally take place three months or more following the child's death, allowing sufficient time for information to be gathered from all relevant agencies.

During the meeting, a draft analysis form is completed. This document summarises the key information discussed, including factors contributing to the death and any identified learning. The draft analysis is subsequently presented to the Child Death Overview Panel (CDOP), where it is reviewed and confirmed as part of the wider child death review process.



NATIONAL & LOCAL CONTEXT

Child deaths in England and across North Yorkshire and the City of York

THE NATIONAL PICTURE

NCMD | Year ending 31 March 2025



2025-2026 LOCAL SNAPSHOT

1 April 2025 to 31 March 2026



AGE PROFILE

Most deaths occurred in infancy



LOCAL REFLECTION

The local pattern, with most deaths occurring in infancy, is consistent with the national picture. There were no deaths among children aged 1-4 years in 2025-2026.

NATIONAL EVIDENCE REINFORCES THE IMPORTANCE OF

SAFE SLEEP

MATERNAL HEALTH

EARLY RISK

MULTI-AGENCY WORKING

Sources: National Child Mortality Database, Child Death Review Data Release 2025; local CDOP data 2025-2026.

North Yorkshire and City of York Child Death Overview Panel



CHILD DEATHS AT A GLANCE

North Yorkshire and City of York • 2025/26

A clear snapshot of local child death data and key inequalities

TOTAL DEATHS

30

2025/26

Between 1 April 2025 and 31 March 2026, 30 children and young people resident in North Yorkshire and the City of York sadly died.

The infographic below highlights the key patterns in the local data.



30

TOTAL DEATHS

20 North Yorkshire • 10
City of York



21

INFANT DEATHS

70% occurred under one
year of age



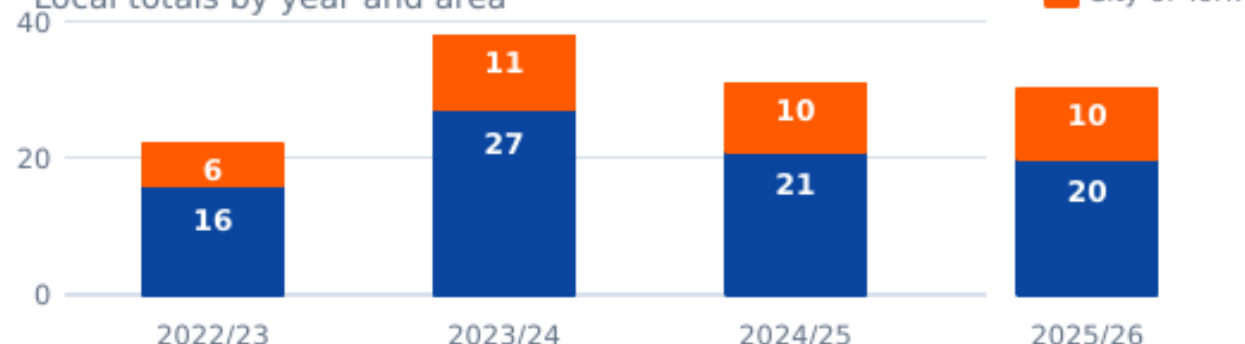
21

EXPECTED DEATHS

7 in 10 deaths were
expected

DEATHS OVER TIME

Local totals by year and area



EXPECTED OR UNEXPECTED



Expected 21
Unexpected 9

An expected death is one anticipated
because of an identified life-limiting
condition.

AGE PROFILE

21

UNDER 1

70% of deaths

0

AGES 1-4

No deaths recorded



GENDER PROFILE

63% male

19 male • 11 female

Local data reflects
the national pattern
of higher mortality
among males.

ETHNICITY



70% White British 21

7% Asian British 2 23% Black or Black British 7



NATIONAL EVIDENCE

● Deprivation

● Ethnicity

● Maternal age and health

● Low birth weight and
prematurity

National evidence demonstrates that child mortality is associated with these factors.

DATA SOURCE Local child death data, North Yorkshire and City of York, 2022/23 to 2025/26.

Figures are based on children and young people normally resident in North Yorkshire or the City of York.

Annual Report • 2025/26

Categories of deaths regarding children who have died in our area

All child deaths discussed at Child Death Overview Panel are categorised using a national template “analysis form” provided by the National Child Mortality Database. This information is reported back to the National Child Mortality Database who annually provide national data on deaths of children. See below for further details in the table regarding categories for North Yorkshire and the City of York.

CDOP reviews by category and year, 2022/2023 to 2025/2026					
Category	2022/2023	2023/2024	2024/2025	2025/2026	Total
Deliberately inflicted injury, abuse or neglect	0	0	1	0	1
Suicide or deliberate self-inflicted harm	1	2	2	2	7
Trauma and other external factors	1	3	2	5	11
Malignancy	5	1	4	5	15
Acute medical or surgical condition	0	1	0	2	3
Chronic medical condition	0	0	4	1	5
Chromosomal, genetic and congenital anomalies	1	3	5	10	19
Perinatal/neonatal event	11	4	3	8	26
Infection	2	1	0	0	3
Sudden unexpected, unexplained death	4	0	4	2	10
Total number of child deaths reviewed by CDOP	25	15	25	35	100

Data

National data consistently shows that the largest categories of child deaths are:

- Perinatal events
- Congenital, chromosomal and genetic conditions
- Sudden unexpected deaths in infancy and childhood (SUDIC)

Congenital conditions alone account for a substantial proportion of infant deaths (approximately one-third nationally)

Local comparison:

The distribution of deaths in North Yorkshire and City of York aligns closely with national trends, with perinatal and congenital conditions representing the largest categories.

Insight:

This alignment suggests that local patterns are broadly typical, and that prevention efforts should continue to focus on nationally recognised priorities such as:

- Maternal health
- Antenatal and neonatal care
- Early identification of vulnerability

What we know

Benchmarking against National Child Mortality Database data provides reassurance that:

- Local findings are robust and representative
- Identified priorities are evidence-based and nationally recognised

It also reinforces the need to:

- Continue aligning local practice with national learning
- Focus on prevention and early intervention
- Address inequalities that underpin many child deaths

100 children and young people who have died in our area have been reviewed by panel over the past 4 years. In 2025/2026 the majority of children and young people who died was as the result of a Chromosomal, genetic and congenital anomalies, with the next most common category being recorded as Perinatal/neonatal event.

Due to child death review processes some children and young people may not be heard at the panel meeting in the year they have died as other statutory processes, further investigations (toxicology, genetic testing, police investigations) and information gathering from agencies is required. It should be noted that a child’s death cannot be discussed at panel until all information is received.



Learning and Modifiable Factors

How do we know we are making a difference

Modifiable Factors and Learning

A core purpose of the Child Death Review process is to identify whether there were any modifiable factors present in a child's death. Modifiable factors are those where changes at an individual, community, service or system level may help reduce the risk of future child deaths.

The consideration of modifiable factors is not about attributing blame to families or professionals. Instead, it provides an opportunity for partners to reflect on whether different support, information, environments or interventions could have reduced risk and how learning can be used to strengthen safeguarding and prevention activity locally.

During the reporting period, the Child Death Overview Panel reviewed all completed cases and considered whether modifiable factors were present. Where identified, these were discussed in detail and agreed by the multi-agency panel.

What the data is telling us?

National Child Mortality Database analysis highlights the most frequently identified modifiable factors across England are.

For infants under 1 year:

The most common include:

- Maternal health factors (including high maternal BMI)
- Smoking during pregnancy or within the household
- Unsafe sleeping arrangements (including co-sleeping in hazardous circumstances)
- Parental substance misuse
- Delays or issues in treatment or care pathways
-

For children aged 1–17 years:

Common factors include:

- Poor communication or information sharing between services
- Failure to recognise deterioration
- Gaps in service provision
- Supervision and environmental risks



Local Comparison

The modifiable factors identified in North Yorkshire and City of York including:

- Safe sleep risks
- Parental health and wellbeing
- Recognition of illness
- Environmental factors

and are highly consistent with those identified nationally.

This consistency indicates that:

- Local learning reflects wider national evidence
- Prevention strategies should remain aligned with national campaigns and guidance
- There is continued importance in targeting vulnerable families, where multiple risk factors often coexist

In 2025–2026, modifiable factors were identified in a small number of cases, consistent with previous years. The factors identified reflected themes seen both locally and nationally and included:

- Substance misuse, including alcohol.
- Unsafe sleeping arrangements for infants.
- Smoking/vaping in pregnancy.
- Co-sleeping in parents' bed.
- Domestic abuse.
- Dampness in house
- Maternal health
- Prop feeding (is an unsafe feeding practice where an infant's bottle is held in place using an object (such as a pillow, blanket, rolled towel, or a commercial device) so the baby can drink without a caregiver holding it. It is associated with an increased risk of choking and aspiration of feeds.

These factors did not occur in isolation and often sat alongside wider contextual issues within families' lives, including health needs, emotional wellbeing, and social pressures.

Learning from this year reinforces several important messages for safeguarding partners:

- Risk often increases at times of transition or stress, such as during pregnancy, in early infancy, or at social occasions where routines change.
- Health behaviours before and during pregnancy remain a key influence on infant outcomes.
- Clear, consistent and repeated messages are necessary, particularly around safe sleep and the impact of alcohol and substances on parenting capacity.
- Professional confidence to have sensitive conversations is crucial in identifying emerging concerns early and supporting families in a non-judgemental way.

Together, this learning highlights the importance of prevention work that begins early, is sustained, and is embedded across universal, targeted and specialist services.

Learning

As a result of learning from child deaths reviewed during this period, safeguarding partners across North Yorkshire and the City of York have taken a number of actions, including:

- Refreshing and promoting professional guidance on safe sleep and parental supervision
- Delivering multi-agency training that focuses on alcohol, substance use and parenting capacity.
- Strengthening key public health messages through coordinated communication campaigns
- Ensuring that learning from CDOP is shared routinely with safeguarding sub-groups and frontline practitioners.

The Child Death Overview Panel remains committed to using learning from every child's death to improve outcomes for children and families. Identifying modifiable factors, even where they are few, provides valuable insight into where collective action can make the greatest difference.

By embedding learning into training, practice guidance, commissioning and public health activity, partners aim to reduce preventable risks and strengthen support for families at the earliest possible stage.

While learning continues to inform improvement, the Panel recognises that some risk factors are persistent and complex, requiring long term, system wide approaches. In particular:

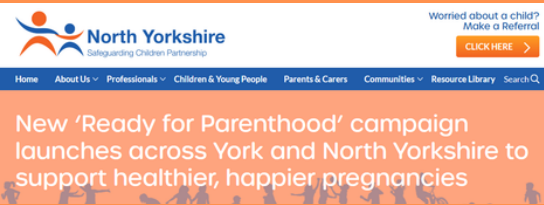
- Supporting families to make healthy choices before pregnancy, not only during it
- Ensuring consistent understanding of risk across agencies
- Balancing clear safeguarding messages with compassionate, relationship-based support

Child Death Overview Panel Priorities 2025/2026

The Child Death Overview Panel (CDOP) has dedicated significant time to preparing for the launch of the Ready for Parenthood initiative, which was successfully launched on 13 April 2026. This has included developing clear and effective communications to support the rollout, alongside creating short videos to promote key public health messages to prospective parents and partner agencies.

Throughout the year, we have continued to actively promote our Who's in Charge and Be Bright, Be Seen, Be Safe campaigns, reinforcing key safety messages for children, young people, and families. Through strong partnership working and targeted communications, these campaigns have helped to raise awareness of risk, encourage safer behaviours, and support professionals and communities to recognise and mitigate potential harm.

Our ongoing focus has ensured that these important prevention messages remain visible, consistent, and embedded across the system.



What have we done?

CDOP has strengthened its impact this year by combining robust case review processes with service feedback and continuous learning to drive measurable improvement. Through the routine use of Survey Monkey feedback within the 0–19 Service, over 1,150 parent responses (April 2025–January 2026) have informed service development, with a strong overall satisfaction rating of 4.57 out of 5 and 84% of families rating the service as good or very good. This ensures that the voices of children, young people, and families directly shape service delivery through the IMPACT workstream.

CDOP processes have provided a systematic approach to identifying modifiable factors across child, social, physical, and service domains, enabling targeted improvements and reinforcing best practice. Positive outcomes and examples of excellent care are captured and shared, supporting a balanced learning culture that recognises what works well alongside areas for development.

Learning is translated into practice through feedback loops, practitioner briefings, and multi-agency collaboration, ensuring continuous improvement across the system. This includes strengthened prevention activity and behaviour change approaches, such as the Youth Outcomes Panel traffic diversion programme, which aims to reduce risk-taking behaviours among children.

As a result, CDOP is contributing to improved service quality, greater user satisfaction, and safer outcomes for children and families. Over time, this work is hoped to reduce harm and see fewer children engaging in high-risk behaviours, including those that could lead to involvement in the criminal justice system.

How CDOP Has Made a Difference 2025–2026

During 2025–2026, the Child Death Overview Panel (CDOP) has made a significant difference by identifying learning from child deaths and translating that learning into practical improvements across services, with the aim of preventing future deaths and reducing harm to children and young people. Key impacts include:

- Strengthening multi-agency learning and practice through case reviews, Joint Agency Response meetings, and the Practice Learning Subgroup, ensuring lessons learned are shared across partner agencies and embedded into training, supervision, policies, and practice.
- Identifying and addressing modifiable factors by reviewing the child's circumstances, family functioning, wider health needs, social environment, and service provision. This has enabled agencies to implement targeted improvements and strengthen safeguarding arrangements.
- Promoting prevention and public health messages, including safe sleep, ICON, Who's in Charge, Be Bright, Be Seen, Be Safe, and the newly launched Ready for Parenthood campaign (April 2026), helping families make informed choices and reduce avoidable risks.
- Ensuring the voice of families is heard by incorporating family feedback into the review process and using lived experience to inform learning and service development across the partnership.
- Improving professional practice through enhanced training, professional challenge, professional curiosity, and supervision, helping practitioners identify concerns earlier and respond more effectively to children and families.

- Supporting equitable access to services through the Healthy Child Programme and targeted interventions, particularly for vulnerable families and those living in rural communities, helping to reduce health inequalities.
- Recognising and sharing examples of excellent care, promoting a culture of continuous improvement and highlighting effective interventions that have positively impacted children and families.
- Influencing wider safeguarding and prevention initiatives, including the Youth Outcomes Panel traffic diversion programme, which aims to reduce risk-taking behaviours and prevent children entering the criminal justice system through education and early intervention.
- Using feedback and evidence to drive improvement, with over 1,150 parent responses informing service development within the 0–19 Service. Families rated the service highly, with an average score of 4.57 out of 5 and 84% reporting a good or very good experience.

Overall, CDOP has helped create a stronger learning culture across the partnership, ensuring that lessons from every child death contribute to safer practice, better services, and improved outcomes for children, young people, and families across North Yorkshire.

What We Will Do Next

Over the next year, CDOP and partners will build on current progress by strengthening practice, embedding learning, and continuing to improve outcomes for children and families.

HDFT 0–19 Service will implement a cumulative risk model through the development of a Standard Operating Procedure (SOP) and dedicated staff training, ensuring practitioners are better equipped to recognise and respond to emerging risk. Ongoing supervision and training will continue to promote professional curiosity and constructive challenge, alongside increased access to multi-agency and safeguarding training opportunities.

We will maintain high-quality delivery of mandated public health contacts, aiming to sustain at least 90% coverage, while continuing to gather and use family feedback. CDOP processes will ensure that the voices of families are consistently heard and embedded into learning, strengthening the influence of lived experience on service improvement.

CDOP will continue to review key factors affecting children’s lives, including family functioning, wider health needs, and social determinants such as income, education, and engagement with services. Learning from both positive practice and areas for development will be shared across the partnership to support continuous improvement.

Finally, we will evaluate the impact of new and ongoing initiatives at 6 and 12 months, ensuring that changes lead to measurable improvements in practice, service quality, and outcomes for children and families.



Child Death Overview Panel Priorities

2026/2027

Priority: Ready for Parenthood

The Child Death Overview Panel (CDOP) for North Yorkshire and the City of York launched in April 2026 a communications campaign called “Ready for Parenthood” focused on reducing harm in pregnancy. This campaign aims to support mothers and mothers-to-be to make informed, positive lifestyle choices relating to nutrition, movement, and emotional wellbeing.

The campaign seeks to:

- raise awareness of behaviours that can reduce harm during pregnancy.
- share simple, practical messages from trusted professionals.
- highlight real experiences from residents who have benefitted from local support services.
- encourage other families to access help early and make lifestyle changes that contribute to healthy pregnancies.

The Child Death Overview Panel will continue to promote this campaign and its key messages over the next 12 months.

Training and Campaigns

The Designated Doctor for Child Death and the Child Death Review Officer delivered Child Death Review: Advanced Training for Professionals across North Yorkshire and the City of York during 2025/26. Fourteen multi-agency professionals attended the two training sessions, enhancing their understanding of the child death review process and their role within it. To improve accessibility and increase the reach of the training, a recorded version is being developed. This will enable professionals to access the training at a time that is convenient for them, reducing barriers associated with attendance, supporting workforce development across agencies, and providing a valuable resource for both existing and newly appointed staff.

CDOP training is accessible for free across North Yorkshire and City of York Safeguarding Children Partnerships and is available to book via the North Yorkshire Safeguarding Children Partnership websites: [NYSCP Training](#) and City of York [CYSCP](#)

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