



# Protecting Babies and Young Children

Thematic learning from local safeguarding reviews

## Introduction

Recent local review activity involving babies and very young children has identified recurring safeguarding themes around non-accidental injury, cumulative vulnerability, professional curiosity, information sharing and the visibility of both parents.

These are not new findings. The 2024 Baby Eva review identified ineffective information sharing and seeking, missed opportunities for early intervention, non-accidental injury, parental engagement and the need to understand fathers' histories and connected children.

More recent review activity has identified similar issues. In one Rapid Review, vulnerabilities were known across several agencies but were not consistently brought together into a shared safeguarding analysis. In a separate Case of Concern review, important information was fragmented across systems, sibling records and agencies, with assumptions contributing to delay in identifying and responding to a newborn child.

The challenge for the partnership is therefore not simply identifying learning. It is ensuring that learning changes practice.

The safeguarding system continues to invest significant time and resource in reviews, audits and learning activity. However, participation in learning opportunities remains lower than expected in some parts of the workforce.

When learning remains concentrated amongst safeguarding specialists and managers, the practitioners who see children and families every day may never encounter it. If learning from reviews is to improve outcomes for children, it must move beyond the review room and into everyday practice

**This learning was already visible in the 2024 Baby Eva review.**

[Read the 2024 Baby Eva briefing 7](#)

# Key Lines of Enquiry

The following questions and findings bring together learning from recent local reviews involving babies and very young children, and help agencies consider whether similar gaps may affect other children.

## KLOE 1

### Cumulative vulnerability and the whole family picture

- How effectively were historical information, parental vulnerabilities, family relationships and changing circumstances brought together to understand risk to the child?

#### What we found

Across the reviews, important information was known but not consistently brought together. Vulnerabilities included housing instability, previous social care involvement, parental emotional wellbeing concerns, family adversity and disengagement from support.

A Case of Concern found that significant family history was spread across sibling records and agency systems, making the overall safeguarding picture harder to see when a new baby became known.

## KLOE 2

### Physical injury, professional curiosity and the child's lived experience

- How consistently were signs of possible harm explored, procedures followed and the experience of a non-mobile baby kept central to decision-making?

#### What we found

A Rapid Review identified bruising in a non-mobile infant where the safeguarding pathway was not followed and the explanation provided by caregivers was not sufficiently tested against the wider context.

Repeated health presentations also provided opportunities to consider the baby's lived experience more fully, but concerns were often addressed as individual episodes rather than as part of an emerging pattern.

## KLOE 3

### Multi-agency information, recording and safeguarding systems

- Did agencies actively seek, connect and analyse information, and did recording systems support professionals to identify children requiring safeguarding attention?

#### What we found

The Case of Concern found that information about a new baby was not always visible within core recording systems, with reliance on emails and assumptions that the child was already known because a sibling was open to services. This contributed to delay.

The Rapid Review found a similar system issue: agencies held relevant information, but it was not consistently aggregated and analysed into a shared understanding of vulnerability and risk.

## KLOE 4

### Engagement, escalation and applying learning

- When concerns accumulated or engagement reduced, were risks reassessed, escalated and informed by learning already identified through previous reviews?

#### What we found

Across the reviews, changes in circumstances, disengagement and accumulating concerns did not always trigger renewed assessment, escalation or stronger multi-agency coordination.

Crucially, the Rapid Review concluded that the main issue was not a lack of learning, but the persistence of familiar themes and inconsistent application of learning already identified through previous local and national reviews.

## What this suggests for the wider system

Taken together, these findings suggest a recurring implementation gap rather than a shortage of safeguarding learning. Information may exist, vulnerability may be recognised and lessons may already have been identified, but children remain at risk when these are not connected, translated into action or embedded across the wider frontline workforce.



# The 6 System Commitments

**“Effective engagement with a vulnerable child’s parents [is] a necessity, not an option.”**

[Protecting all vulnerable babies better](#) calls for safeguarding systems to be **proactive, relational** and **trauma-informed**, with agencies working together to anticipate risk, understand non-engagement and keep both the child and the wider family context in view.

1

## Engage Relentlessly

Persistent non-engagement must not block safeguarding activity. Understand why engagement is difficult, use trusted professionals, and adapt the approach without losing sight of risk.

The national review explicitly says systems must persist in trying to engage parents and build trust where trust does not yet exist.

### Reflective Question:

What is getting in the way of engagement, and how can we adapt our approach without losing sight of the child?

2

## Hold the Whole Family Picture

Bring together the child’s history, siblings, parental experiences, domestic abuse, mental health, housing and wider family context.

The national review emphasises whole-family working and warns against understanding a baby in isolation from what has happened before.

### Reflective Question:

What do we know about each parent, sibling and significant adult – and what is still missing?

3

## Anticipate Risk, Do Not Wait For Crisis

Safeguarding vulnerable babies requires proactive planning where there is known adversity, previous harm or emerging concerns during pregnancy and early infancy.

Local reviews found that concerns were recognised, but did not lead to a clear pre-birth assessment or shared understanding of risk to the baby.

### Reflective Question:

What could happen next if circumstances do not improve, and are we acting early enough?

4

## Think Cumulatively

Look for patterns across time and agencies. Individual concerns may appear manageable, but together they can indicate increasing vulnerability or harm.

This aligns strongly with both the Rapid Review and the national review’s emphasis on cumulative family history.

### Reflective Question:

What pattern emerges when we look across time, incidents and agencies?

5

## Use the Whole System

**Safeguarding vulnerable babies is not a children’s social care task alone.**

Health, police, probation, housing, adult services and voluntary-sector partners all hold pieces of the picture and need to act collectively.

### Reflective Question:

Who else may hold information or insight that could change our understanding of risk?

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## Turn Learning into Practice

Where themes recur across reviews, the issue is no longer simply identifying lessons. The system must test whether those lessons are actually changing frontline behaviour.

This directly reflects the Rapid Review conclusion that the problem was inconsistent application of learning already identified.

### Reflective Question:

What are we doing differently because of previous review learning, and how would we know it is making a difference?

Explore further learning from local reviews and safeguarding practice at [croydonsafeguarding.org](https://croydonsafeguarding.org)

**Stronger questions. Brighter practice. Better outcomes for children.**