NSPCC Repository February 2025

In February 2025 eight case reviews were published to the NSPCC Repository featuring a number of issues including sibling sexual abuse, suicide, neglect identification, and intersectionality.
Previous NSPCC Repositories and published Torbay local child safeguarding practice reviews can be found on our website: Child Safeguarding Practice Reviews - Torbay Safeguarding Children Partnership

1. Child Safeguarding Practice Review: Smith family

Disclosure of sexual abuse to a 13-year-old girl by a relative in November 2023. The large Smith family had been known to services for ten years and there were significant concerns around neglect and poor home conditions. The relative and both parents were arrested. Learning considers: children living in conditions detrimental to their health and development; school attendance and support with transitions; sexual abuse in the family environment and the vulnerability of neglected children; reoccurrence of neglect; and the impact of poverty and poor housing conditions alongside neglect. Recommendations to the partnership include: refresh its neglect strategy, to include agreed identification and assessment tools, and ensure the relationship between sexual abuse and neglect is clear; seek assurance about the delivery and progress of plans to improve system-wide understanding and response to educational neglect; publish and deliver a strategy that outlines an agreed approach to child sexual abuse (CSA), including training to support confident practice in identifying and responding to CSA; continue to promote the use of chronologies and genograms across agencies so that families' stories are known, including parents' own childhood histories and the involvement of wider family members; the relevant statutory partners should provide assurance that police powers of protection are being used appropriately and that NICE guidelines are being followed in medical settings when genital injuries are present; and child protection conference practice should be reviewed to ensure that time is available for each child to be considered appropriately when there is a large sibling group.

Other resources Read practice review (PDF)

2. Child 'Marcus': Child Safeguarding Practice Review – a thematic approach

Thematic review concerning children from two families with similarities in their experiences of service provision. A 1-year-old infant presented to hospital in March 2023 with malnourishment and anaemia, and safeguarding concerns arose in relation to two children aged 4- and 5-years-old following allegations of domestic abuse. Learning themes include: working with families where engagement is reluctant and sporadic; Covid-19; professional curiosity; intersectionality; ensuring families receive the right help at the right time following a change in service provider; and understanding thresholds in the context of children with complex/additional needs. Recommendations include: health partners to provide assurance to the partnership that when a service is delivered virtually account is taken of identified vulnerabilities and an evaluation is undertaken to ensure there has been no impact on the quality of care; partners to provide

assurance to the partnership that the services provided to families with children adopt culturally competent practice that fully considers the implications of intersectionality and the impact this may have on engagement with services; and when a health provider changes, the outgoing and incoming provider should work together to ensure a smooth transition, and the partnership should be made aware of any risks identified by the new provider, having taken account of feedback from staff and workforce trends.

Other resources **Read practice review (PDF)**

3. Local Child Safeguarding Practice Review: Emily and Ryan

Explores the circumstances which led to a serious sexual assault of a 16-year-old girl that was looked after in supported accommodation by a 17-year-old boy who was also looked after in supported accommodation. Learning includes: ethnicity and gender appear to be factors in child criminal exploitation; known risk factors around vulnerability don't always act as predictors; exclusion from mainstream school is seen as a trigger point for risk of serious harm; building a trusted relationship between children and practitioners is essential to effective communication and risk management; parental engagement is nearly always a protective factor; and the National Referral Mechanism is not well understood and is inconsistently used. Recommendations include: develop a system and protocol for lead workers in complex cases, the issue is time allocation and professional support for anyone given the role of managing information and sharing intelligence in complex cases; the services for young people who have suffered domestic abuse should ensure that risk assessments completed by other agencies are included in risk assessments to fully understand the level of risk; consideration of the appropriateness of the DASH assessment tool where the victim and perpetrator are both legally children; ensure that awareness and knowledge of trauma-informed practice model are embedded in all assessment tools; where there are domestic abuse concerns between children and young adults who are subject to the National Referral Mechanism these issues should be considered as part of an ongoing assessment of risk; and ensure that these assessments are proactively progressed and completed where there is a concern that a young person may have special educational needs or disabilities.

Other resources Read practice review

4. Learning report from a combined Safeguarding Adult Review and Child Safeguarding Practice Review

The prevalence of abuse and exposure to violence was seen as significant in the children's lives and learning was derived from this combined safeguarding adult review and child safeguarding practice review. Learning includes: ability of professionals to work in a multi-agency capacity to consider all the information they hold (current and historical) about vulnerable children, in particular the information held by schools; provision of timely feedback to referrers on referral outcomes and the use of the local escalation process where professionals disagree on the right course of action; multi-agency oversight of children experiencing multiple reported incidents of abuse and the maintenance of that oversight where alleged victims decline support services; multi-agency assessment of and response to neglect to ensure that theoretical frameworks guide assessments and that children's lived experience and full life histories are considered; ability of professionals

working with children to identify adult safeguarding concerns and follow adult safeguarding procedures; ability of adult services, children's services, and community safety services to work together to respond to safeguarding concerns; multi-agency approach to welfare checks; engagement of fathers and wider family members, as well as mothers, in the assessment of vulnerable children's lives and safety planning to reduce the risk of significant harm; and understanding across all professionals working with families, adults, or children of what constitutes a private fostering arrangement.

Other resources **Read practice review (PDF)**

5. Local Child Safeguarding Practice Review: Jasper Red

Death of a 17-year-old boy by suicide in 2023. There were two known occasions where Jasper Red had taken overdoses prior to his death, and at other times he shared suicidal ideation with professionals. Jasper Red experienced neglect and abuse as a young child and spent time on a care order and in the care of West Sussex local authority from 3-years-old. Learning explores: information sharing and communication when a child moves between areas; consideration of a parent's history, on-going issues, and ability to meet a child's emotional needs; assessment and support when a child is struggling with their mental health and has suicidal ideation; impact of a child's learning needs and sexuality on their vulnerability and mental health; and the need for those working with adults to consider the wider family context. Recommendations include: the NHS Foundation Trust to provide an update to the Partnership on the work being undertaken to ensure improvements in safety planning for children who are known to be a suicide risk; the Partnership considers how they can ensure optimum learning across agencies about cumulative harm; and relevant health agencies consider how they can improve practice in respect of appropriate access to information and information sharing about mental health.

Other resources Read practice review (PDF)

6. Serious Case Review: Overview report: Olivia

Olivia died in July 2019 when she was 5-months old. Her cause of death was unable to be established. Learning includes: the failure to identify the full picture of the families' domestic circumstances must represent a missed opportunity for the agencies involved; there are several references in this case to professionals conducting routine enquiries, there is a risk that this procedure is carried out during appointments purely to satisfy the rules; failure to identify the complete domestic picture and share this information fully between appropriate agencies must be seen as a missed opportunity; and whilst staff consistency can never be mandated because of inevitable issues such as sickness or staff changing roles, managers must be aware of the risks. Recommendations include: assure itself that health providers policies reflect the need for routine enquiries to be conducted in a detailed manner; incidents of domestic abuse are subject to appropriate supervision and scrutiny, this should ensure that in all cases, risk assessments are submitted following oversight from a supervisor, they should also assure themselves that training is available and mandatory for initial responders to such incidents; MASH policies and processes should be reviewed by all appropriate agencies to ensure that whenever possible a full picture of risk is identified and shared between relevant agencies in a timely manner; lack of consent should

not be a barrier to information sharing if it would ensure safeguarding is fully considered; and all agencies are conscious of the risks associated with frequent changes of professionals.

Other resources Read practice review (PDF)

7. Learning Review Executive Summary: Baby M

Removal of a newborn baby from his mother in April 2023. A Child Protection Order (CPO) was granted due to increasing concerns about Ms A's mental health and her ability to safely care for her child. Ms A was diagnosed with paranoid schizophrenia in 2012 and had been detained under the Mental Health (Scotland) Act 2015 on several occasions prior to the birth of Baby M. Learning/recommendations include: perinatal and adult mental health services should develop guidance that sets out joint working relationships and communication between services; the special needs in pregnancy team (SNIPS) and adult mental health services should develop interface guidance to enhance appropriate communication and information gathering; adult mental health services should develop guidance for the co-ordination and care of all patients who present as pregnant; the CPC should seek reassurance from adult social work and health services, that practitioners have a clear understanding of their responsibilities in relation to child protection; NHS Greater Glasgow and Clyde (NHS GG&C) should clarify what systems midwives have access to at the point of booking and should clearly set out what systems midwives should access to ensure consistency of practice; NHS GG&C should review current mental health awareness training for midwifery staff and identify potential gaps; the CPC should review current guidance to ensure that professionals are clear about how they refer, the paperwork they use and the threshold for referral; NHS GG&C and the CPC should review the current pre-birth pathway for vulnerable women in pregnancy; NHS GG&C should ensure full implementation of the health visiting ante-natal pathway as set out in the universal pathway.

Other resources Read executive summary online: www.renfrewshire.gov.uk/media/16928/Baby-M-Learning-Review-Executive-Summary-Report/pdf/Baby_M_Renfrewshire_Child_Protection_Committee_Learning_Review_Executive_Summary.pdf?m=1731582513927

8. Local Child Safeguarding Practice Review: Isaac, Sibling 1 and Sibling 2

Explores the experiences of Isaac, a 10-year-old boy, who reported that his two siblings had behaved in a sexually inappropriate way towards him, later disclosing he had been sexually abused. Recommendations are embedded in the learning. Learning includes: children need to be enabled and supported to talk about child sexual abuse; help seeking behaviour needs to be responded to positively; careful thought needs to be given to how 'no further action' is communicated to a child or family; when children share concerns and then retract them, this requires appropriate professional analysis to consider what this means in the context of the child's needs and circumstances; there needs to be certainty about the threshold for action regarding sibling sexual behaviour; thought needs to be given about how 'no further action' in criminal justice processes is communicated to children and their families; confusion about whether professionals can talk to children about sexual abuse whilst criminal investigations are ongoing needs to be addressed; there needs to be more readily available support for children who have been sexually abused; the

work of schools to meet the needs of children who have been abused should be included in child protection and child in need plans; professionals need to help children who have experienced sexual abuse understand the link between what has happened and the difficulties they are experiencing to avoid internalising a sense of 'something being wrong with them'; children need trauma focussed services to heal from sexual abuse; family dynamics need to be understood to make family healing and recovery possible; and the role of child protection conference chairs' in ensuring that child protection plans are actioned and fit for purpose is critical.

Other resources Read practice review (PDF)