NSPCC Repository March 2025

In March 2025 eight case reviews were published to the NSPCC Repository featuring a number of issues including child sexual exploitation, child criminal exploitation, childhood illness, and foster care. 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: Mikoto

Fatal stabbing of a 16-year-old boy in 2023. Mikoto was arrested with a weapon and drugs a few weeks before he was killed. There were concerns around school exclusion, exploitation and serious youth violence.

Learning includes: the importance of relationships between professionals and the child and their parent/s; the need for robust multi-agency responses to 'critical moments'; the impact of school exclusion; professional and system awareness and consideration of intersectionality and adultification; improving contextual safeguarding and the wider local strategic picture; the complexity of cross border working; and neurodiversity and exploitation.

Recommendations to the partnership include: ask the local violence reduction alliance and public health to work with the partnership to review and streamline preventative workstreams, including how to evidence the impact on multi-agency frontline interventions to tackle serious youth violence and child criminal exploitation for individual children and their families; work with other partnerships regionally to develop a protocol which ensures that children living in one area but receiving services in other areas receive needs led services and joint working that is not determined by the child's postcode; ensure that practice demonstrates the importance of identifying, recognising and challenging intersectionalism and adultification, including training across agencies and a review of processes; and instruct that partner agencies review their processes and training to ensure that staff have the tools to work with children who present with autism, ADHD or neurodiverse characteristics.

Other resources Read practice review (PDF)

2. Child Safeguarding Practice Review: Isabella

Death of a 2-year-old girl in June 2023. Isabella had suffered significant non-accidental injuries. Isabella's mother's partner was found guilty of Isabella's murder and Isabella's mother pleaded guilty to causing or allowing her death. Isabella, her mother and her mother's partner were known to agencies due to concerns including domestic abuse, mental ill health, and homelessness.

Learning themes include: risk assessments pre- and post-birth; risk assessments when a family moves local authority areas; unknown information about a parent's partner; the response to alleged domestic abuse when children are in a household; information sharing between local

authority areas; housing when homeless and young children are involved; intersectionality; and the impact of Covid.

Recommendations to the Partnership include: ensure that the voice and lived experience of children, including those who are unable to fully communicate verbally, are always included in agencies' actions and assessments; ensure that assessments and interactions with families consider the role, presence and history of partners living in or associated with a household; support professionals in understanding the options available in cases involving domestic abuse and neglect, and where children are impacted by homelessness or living in unsuitable accommodation; ensure that the local neglect strategy identifies unsuitable accommodation and rough sleeping as risk factors of neglect; deliver training and guidance to raise professionals' awareness, knowledge and understanding of domestic abuse and neglect, including how to recognise coercive control; promote the use of multi-agency meetings; promote cross-border information-sharing, risk-assessment and decision-making; and ensure agencies consider individual learning needs and make reasonable adjustments.

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

3. Child Safeguarding Practice Review: Devon and Lancashire: a child centred review of learning, barriers and challenges following a review of the significant harm suffered by Child Sydney

Serious incident involving a 13-year-old-girl in April 2023. Sydney and a friend went missing from their placement and were located by police five days later. They disclosed that during this time they had been drinking, taking drugs and were sexually assaulted by several older males. Sydney has a history of trauma, mental health difficulties and repeated missing episodes.

Learning explores: ASD assessment delays; missed opportunities for risk assessments; and responding to contextual safeguarding risks for vulnerable children.

Recommendations to Devon Children's Services include: raise awareness of the 'out of area placements policy' to ensure that all relevant information is shared with the host local authority (LA) at the earliest opportunity; ensure that health records and notifications can be shared with the receiving Integrated Care Board; ensure that risk assessments are regularly reviewed and updated; equip all children in care with a safety plan in the event of a missing episode; ensure that the new version of the Safer Me Assessment is embedded within the electronic recording system as a matter of priority; provide further guidance to practitioners regarding timely applications to court to protect vulnerable children; develop practice guidance in relation to the matching of children within placements and matching to their allocated social worker; when challenging health or additional needs are identified, discussions should include CAMHS/health services; ensure that a manager has oversight of any missing episode that reflects safeguarding concerns and there is a direct conversation between both LA's to agree responsibility; and the Partnership should work with health providers to resolve drift and delay in completing ASD or ADHD assessments.

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

4. Local Child Safeguarding Practice Review: Ruby and Daisy

Death by suicide of a 13-year-old girl in 2023. Ruby and her sister Daisy had received support from various agencies due to mental health difficulties, Daisy from 2019 and Ruby from 2021. Between 2019 and 2023, referrals were made to and from multiple agencies regarding concerns including domestic abuse and child sexual abuse.

Learning themes include: intrafamilial child sexual abuse; the need to consider all the needs of each family member and how these may compound a family's difficulties; a child's lived experience; children's peer relationships; Gillick competency; parental refusal of services; the use of chronologies; intra- and extra-familial harm; domestic abuse; risk-taking behaviour; privately commissioned healthcare providers; escalation and professional challenge policies; and the use and checking of information during strategy discussions.

Recommendations to the Partnership include: produce a learning briefing on emotionally abusive parenting, offering clear descriptions harmful parental behaviours; consider how to systematically review and respond to patterns of refusal of intervention by a family; ensure that, where relevant, assessments and referrals consider and reference the impact of the online world and social media on children and families; develop a communications strategy to highlight to third- and private-sector organisations local pathways for guidance and the referral of safeguarding concerns; ensure practitioner guidance reflects the significance of a decline in a child's mental health; consider how to action safety plans; and ensure all relevant groups are considered in meetings after a child's death by suicide, to ensure support and signposting has been offered and vulnerable children identified.

Other resources Read practice review (PDF)

5. Child Safeguarding Practice Review: YPW: Summary of learning

Disclosure of abuse and neglect within the foster home by a young person in July 2022. Young Person W developed a functional illness while in this placement, from which they recovered shortly after moving to alternative foster carers.

Learning themes include: the difficulty for children of trusting professionals involved in their removal from their birth family; foster carers acting as the voice of the child; the need to share and act on concerns about foster carers' behaviours; functional illness as a response to anxiety or trauma; the need for communication and a coordinated approach across education, health, mental health and social care services; the relationship between foster carers and local authority children's services providers; and agencies' actions following a disclosure.

Recommendations to the Partnership and local children's services provider include: develop guidance and training on hearing the voice of child; examine barriers preventing the escalation of concerns regarding foster carer behaviour; work with the Metropolitan Police to ensure that officers attending domestic abuse incidents take a proactive approach to establishing the occupation of people in the home, and to explore adding an alert to police records where adults are registered foster carers; when a child in care is diagnosed with a functional illness, review their care plan with practitioners with specialist understanding of possible underlying causes and effective treatments; include professionals from both local authorities in education and health care planning for a child placed out of borough; support professionals in knowing how to respond to allegations against a trusted person; and encourage collaborative partnership working.

Other resources Read practice review (PDF)

6. Child Safeguarding Practice Review: Executive summary: Child Bm

Case of child sexual exploitation (CSE). No details included.

Learning includes: how professionals understood, recognised and responded to signs of CSE; the quality of strategy discussion and the Child and Family Assessment; how professionals understood Child Bm's lived experience and heard their voice; how agencies worked together to safeguard Child Bm from harm; how professionals identified and assessed protective factors; how personal student information was transferred when Child Bm changed school; and whether there were any missed opportunities.

Recommends that the Partnership develops an action plan for improvements to systems and practice including: seek assurance that professionals from all agencies understand the referral processes into the new multi-agency Child Exploitation team and the benefits of seeking guidance and advice from the team when a referral cannot be made; ensure that strategy minutes and actions are being communicated to, and received by, all agencies (including GPs) involved with the child and family; be assured by partner agencies that section 47 checks are identifying wider professional and familial sources who can support risk assessment and intervention; the Healthcare Foundation Trust (on behalf of the Multi-Agency Safeguarding Hub) and the Integrated Care Board should work together with GPs in their area to gain an understanding of GP's knowledge and experience of safeguarding practice, and how this can influence their support with Multi-Agency Safeguarding Hub process; and develop training for schools around the importance of recording conversations within records so that pupils records include robust documentation of safeguarding discussions and plans.

Other resources Read practice review (PDF)

7. Jake: Summary of case and learning

Death of a 17-year-old boy from diabetic ketoacidosis, hyperglycaemia, diabetes mellitus and bronchopneumonia. It has been confirmed by the paediatrician that Jake's death would have been prevented if health care had been sought over the weekend that he was ill. Jake was a vulnerable young person with unmet learning needs.

Learning and recommendations include: schools should always pay specific attention to children with vulnerabilities and learning disabilities and consider that these children will require additional or specific support and services; deeper consideration should have been given to the rationale behind Jake's threatening and challenging behaviour; the number and extent of the concerns across the four school's recording systems should have prompted referrals to Customer First and MASH and at the same time, led to the completion of an Education, Health and Care Plan (EHCP); schools should always contact and communicate with parents when they have multiple and serious concerns regarding children's behaviour and prior to implementing an exclusion; schools should give greater consideration to the implications of excluded children with vulnerabilities and challenging behaviour becoming invisible to services and effectively 'going under the radar'; and

social care should have 'noticed' the other children in the house and considered the risks and concerns for them and the implications of poor parenting and parenting capacity.

Other resources Read learning summary (PDF)

8. Extended Child Practice Review 2023: Child A

Significant drug overdose leading to the hospitalisation of a 17-year-old male and the death of a 28-year-old female in September 2022. Child A had contact with multiple agencies from 2021, due to concerns including untreated seizures, epilepsy, use of illegal substances, lack of parental care, his relationship with Adult B, and child criminal exploitation. He was placed on the child protection register under the category of neglect in October 2021.

Learning themes include: the role of gender bias; recognising and responding to the risk of exploitation; professional curiosity; disguised compliance; the impact of COVID-19; engagement with professionals; medical non-attendance; referral processes; trauma; and the importance of partnership working.

Recommendations to the Partnership include: support practitioners and supervisors in better understanding what child sexual exploitation (CSE) looks like, including cases involving adult females and adolescent males; ensure all agencies recognise and act upon CSE as a modern slavery/human trafficking offence; re-issue Partnership practice guidance on professional curiosity to all agencies; ensure all practitioners are aware of and follow the actions to be taken when children under safeguarding processes are not brought to health appointments; ensure a multi-agency approach is used to engage with children and families; ensure statutory timescales are met by all agencies; remind practitioners of the importance of checking records for accurate information; ensure all relevant agencies are included in practice review panels; consider incidents in context, and take a trauma-informed approach in responding; ensure practitioners receive enough support and supervision; and further agencies' understanding of vicarious trauma.

Other resources Read practice review (PDF)