NSPCC Repository April 2025

In April 2025 eight case reviews were published to the NSPCC Repository featuring a number of issues including child neglect, infant deaths, unknown men, and child sexual abuse
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. Local Child Safeguarding Practice Review: Ava

A 2-year-old girl and her 8-year-old sibling were discovered in a neglected condition in March 2022 by police who had been asked to undertake a welfare visit.

Learning is embedded in the recommendations.

Recommendations include: agencies providing ante-natal care and health visiting services should ensure that there is clear communication between the services, this should include significant events; children's social care should ensure that child and family assessments consider and address all areas of concern and fully consider the relevant history of a case; agencies should ensure that there is in place effective management oversight, which is recorded with clear timescales and where appropriate escalation; ensure that the necessity for timely strategy discussions is re-enforced within their agencies; ensure that the significance of third-party information is recognised in protocols on receiving information, and should audit the theme of cases involving 'anonymous' referral to understand how this information was managed; prioritise across its membership the learning from recent reviews which highlight the need to understand and be professionally curious about changes in relationships; and develop a partnership staff induction pack (sway), which includes recent key learning from reviews.

Other resources Read practice review (PDF)

2. Local Child Safeguarding Practice Review: Children F

Removal of four children aged 2, 5, 8 and 10-years-old into police protection in September 2022 following allegations by Child 3 of sexual abuse by their father and physical abuse by their father and mother. Care and criminal proceedings are ongoing.

Learning explores: working with children with additional needs; elective home schooling and safeguarding vulnerable children; working with vulnerable parents; record keeping; and the impact of intersectional identities and unconscious bias on professional understanding and decision making.

Recommendations for the partnership include: ensure the lived experience of the child is better integrated into practice; ensure professionals understand that adultification of very young Black children where intent is attributed can lead to a failure to recognise their safeguarding needs; strengthen the expectation that all agencies, especially schools, access and routinely use reflective spaces to discuss concerns about children; work with practitioners to develop and build confidence

both in challenging parents and each other; consider how agencies can be supported to liaise with each other about children or families they have in common; set standards and expectations regarding record keeping; consider a review of the child sexual abuse strategy to ensure that children with disabilities or SEN are fully considered; seek reassurance that SEN children are being appropriately safeguarded through an audit across a sample of schools; work with practitioners to further understand the barriers to working more effectively with parents who have learning disabilities or mental ill health; and consider developing explicit guidance for professionals to draw on when the parents' wishes conflict with the needs of the children.

Other resources Read practice review (PDF)

3. Local Child Safeguarding Practice Review: Child J

Suicide of an 11-year-old boy. Child J was placed in foster care at 5-years-old and lived with several foster carers. He experienced significant trauma in his life including emotionally abusive parenting, sibling sexual abuse, self-harm and suicidal ideation, and different forms of discrimination.

Learning themes include: intersectionality and the child's lived experience; the impact of past harm upon children in care; consistent response to the specific needs of children in care such as trauma, mental illness, and neurodiversity; effective placement planning; management of the dynamic nature of risks to children in care; and the impact of COVID-19.

Recommendations to the partnership include: support the multi-agency network to effectively identify and respond to children that may be neurodiverse; consider how to embed the concept of 'intersectionality' into multi-agency assessment and intervention to safeguard children with complex needs; agree expectations regarding what can and should be systematically shared with key partner agencies and placements regarding a child in care's history in order to support a trauma-informed approach to that child's care, health and education; ensure that the multi-agency network around a child with complex needs are included in considering what is important for the child as part of placement matching; and ensure that risk assessment and safety planning for children who have significant histories of trauma and experience self-harm and suicidal ideation is multi-agency in terms of 'ownership', child-centred, and responds to newly identified risk.

Other resources Read practice review (PDF)

4. Child Safeguarding Practice Review: An appreciative inquiry into learning barriers/challenges following a review of the death of Child Jody

Death of a 16-day-old-infant in July 2022. Child Jody was born at 35 weeks in an unplanned home birth. Mother was believed to be under the influence of cannabis at the time. Mother and baby were taken to hospital and discharged a few days later. Nearly two weeks later Jody's mother called an ambulance after finding Jody unresponsive, but Jody was pronounced dead in hospital. The family had been known to services since the birth of Jody's eldest sibling in 2017. Jody's mother had been in care and had extensive involvement with children's services.

Learning is considered in the context of other local and national reviews and includes: understanding of risk, including parental and other adult's histories in relation to assessment and

planning for children; communication between agencies; and the understanding and application of policies and procedures in relation to safeguarding unborn, and new-born babies.

Recommendations include: hold mandatory briefings twice a year on lessons from case reviews; ensure practitioners are aware of what should be included in a S47/ pre-birth assessment and when to undertake a pre-birth assessment; ensure managers in all agencies understand their role as gatekeepers of good practice and that supervision must include guidance and challenge; child protection conference (CPC) chairs should quality assure all reports and feed back to managers when there are concerns about the quality of social work assessments; audit the use of the vulnerable pregnancy pathway; ensure annual refreshers of mandatory safeguarding inductions; ensure that all relevant agencies are invited to strategy meetings; and establish a data sharing warehouse for information sharing between agencies.

Other resources Read practice review (PDF)

5. Local Child Safeguarding Practice Review: Child Z

Death of an 18-month-old child in 2020 from a head injury, whilst in the care of his father's partner (Adult A). Child Z and his family were known to services due to a history of domestic abuse. Adult A had a history of childhood abuse, substance misuse, and domestic abuse, with care proceedings underway regarding her child.

Learning considers: the legacy of relationships characterised by domestic abuse; information sharing; the importance of assessing background Information; and assessing risk to children from risky adults outside of the family home.

Recommendations to the partnership include: commission a multi-agency task and finish group to develop a framework about how and in what circumstances details of individuals and the risk they may pose, can be shared with parents; review their training strategy to ensure practitioners are confident when dealing with families where domestic abuse is a factor - this should include acknowledging the increased risk to women and children when parents separate, the need to keep contact arrangements under review, the importance of not solely relying on victims of domestic abuse to put measures in place to protect children against their domestic abuse perpetrators, and the need for practitioners to consider ongoing therapeutic support for victims of domestic abuse; and ensure that practice is in place whereby fathers are engaged in any risk assessment of their children to protect them from adults who pose a risk.

Other resources Read practice review (PDF)

6. Local Child Safeguarding Practice Review: George and Oliver

Life-threatening incident at a family home involving two siblings, both under 13-years-old, in July 2023. George and Oliver were treated for minor injuries. Their father was found responsible for the incident is now serving a lengthy prison sentence. George and Oliver are now in foster care. The family had been known to agencies since 2012 due to concerns including domestic abuse, the mental health of George and Oliver's mother, and parental contact arrangements.

Learning themes include: working with families where there is domestic abuse, coercive control and alienating behaviours; assessing parental mental health in the context of private law

proceedings; practitioners' understanding of private law proceedings and their impact on children; risk assessment in relation to changing circumstances which may impact the safety of children; and assessing children's lived experiences.

Recommendations to the Partnership include: review training and guidance to support all practitioners in working with families where coercive control and alienating behaviours is or has been a factor; ensure guidance on domestic abuse highlights the importance of exercising professional curiosity about all relationships, exploring potential ongoing risks when parents separate, considering history when assessing risk, and continuing to review ongoing contact arrangements; enhance training and guidance on private law proceedings, including practitioners' roles and responsibilities in supporting children who are subject to them; and support practitioners in understanding intersectionality and considering this as a factor when assessing and managing risks to children and families who experience multiple oppressions and disadvantages.

Other resources Read practice review (PDF)

7. Extended Child Practice Review 2022/2

Removal of a girl from parental care in September 2021 under the category of physical abuse, sexual abuse, and neglect. The child had lost sight in one eye due to the combined effects of a developmental condition and her continuously holding a hand over her eye. The family had been known to services since at least January 2020 due to concerns including poor living conditions, aggressive adult behaviour and relationships, drug and alcohol misuse, and anti-social behaviour. The child had been subject to a child protection plan, which focused on the need to maintain a safe home environment, for the child to not witness violence or abuse, and for the child's health needs to be met.

Learning themes include: sharing information about and responding to concerns; the voice and lived experience of the child; non-attendance at universal, education, and health services; medical neglect; and the response to safeguarding concerns. Details work already undertaken to improve systems and practice.

Further recommendations to the Partnership include: develop digital records to reduce reliance on paper records and promote effective information sharing; share the AWARE pneumonic device developed to help all agencies assess children's wellbeing and needs; establish principles and pathways across all agencies to respond to non-attendance; raise Partnership awareness of medical neglect and the importance of assessing parents' capacity to meet children's health needs; ensure all relevant professionals, including medical practitioners, are present at case conferences; and promote a problem-solving approach to anti-social behaviour.

Other resources Read review online: www.northwalessafeguardingboard.wales/practice-reviews/

8. Local Child Safeguarding Practice Review: Child Charlotte

Rape of a 17-year-old girl in January 2023. Charlotte had been known to agencies since 2007 due to concerns including domestic violence, alcohol abuse by Charlotte's mother, Charlotte's mental health, drug use by Charlotte, and previous reports of rape. Charlotte experienced 11 periods of support as a child in need, most recent to the incident between August 2022 and January 2023.

Learning themes include: the assessment and management of changing risk; a child's legal status under the Children's Act 1989; the management of continuing vulnerability, including episodes of missing from home, homelessness and self-harm; trauma-informed approaches; multi-agency safeguarding arrangements responsibilities; the management of rape allegations; support for children who are at risk of or suffering sexual exploitation; agencies' delivery of corporate parenting responsibilities; and enablers of timely agency responses to harm.

Recommendations to the Partnership include: ensure multi-agency engagement in cases of children in need; ensure comprehensive assessments of children in need which use child and family assessment tools and result in a timely multi-agency action plans; ensure professionals are aware of and use the practice tools available to them; deliver training to all agencies on the impact of early trauma on children; support all staff in understanding the significance of a child's legal status with respect to the management of missing from home episodes; and when reports of rape or sexual assault cannot be followed up through the criminal process, the police should consider what other support services might be helpful.

Other resources Read practice review (PDF)