NSPCC Repository May 2025

In May 2025 eight case reviews were published to the NSPCC Repository featuring a number of issues including child criminal exploitation, child sexual abuse, children who have complex health needs, and non-accidental injury
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. A thematic review concerning Adrian, Henry, and Sam

Incident involving three adolescent boys. The details of the incident are not included in the review. Adrian, Henry and Sam had all been known to services for several years due to concerns including parenting capacity, disrupted education, and child criminal exploitation.

Learning themes include: the adultification of children involved in criminal activity; the vulnerability to criminal exploitation of children missing education; the impact of child neglect and exposure to domestic abuse; the voice of the child; child development and the impact of brain injuries; risk assessments in families where there are known offending histories; information sharing between and within agencies; protective planning and interventions; engagement with children when familial consent is not given; and the impact of professional hierarchies.

Recommendations to the Partnership include: raise awareness of adultification bias; embed cultural competency into case oversight and reflective learning; ensure age and developmental stage are considered in child assessments; promote understanding of adolescent neglect; implement information sharing mechanisms for identifying and monitoring vulnerable children who are missing from school; provide professional learning and development which focuses on adolescent development and neglect; promote the use of chronologies to aid decision-making; ensure the link between a child being exposed to domestic violence and their own offending and risk-taking behaviour is understood; encourage professional curiosity; deliver comprehensive professional development and training on child criminal exploitation; ensure the supervision policies and frameworks of all agencies are regularly reviewed; and promote a culture of mutual respect and professional challenge across all agencies.

Other resources Read practice review (PDF)

2. Child Safeguarding Practice Thematic Review: Non-accidental injury and neglect children under 1yr

Considers four significant incidents involving infants aged 7-10-weeks-old. Children A, B, C and D are from different families. Criminal investigations and care proceedings are ongoing regarding the abuse of Children A and B and the neglect of Child D. Child C was returned to parental care after court proceedings determined their injuries were accidental. Similar themes about multi-agency

service provision emerged from the four rapid reviews. Outlines learning identified during the rapid reviews and how this learning has been progressed.

Learning themes include: the use of partnership policies, including the pre-birth and bruising in babies protocols; responding to pressures on new parents not previously known to agencies; exploring and responding to the impact of parental learning difficulties, physical disabilities, mental ill-health, and isolation; exploring and responding to the impact of a traumatic birth; exploring and responding to the impact of infant behaviour, including feeding difficulties and crying; child protection medical assessments; the use of skeletal surveys; and health representation at strategy meetings.

Recommendations to the partnership include: review and evidence the impact of the pathway between midwifery and health visiting services; monitor and consider the revised healthy child programme workforce model; and identify and share good practice examples of identifying and working with fathers.

Other resources Read practice review (PDF)

3. Child Safeguarding Practice Review: Child N

Disclosure from a girl of sexual abuse by her stepfather in October 2022. Child N has ADHD and received educational and primary care support for cognition and learning difficulties. She and her family had been known to services for a number of years due to concerns including physical and sexual abuse, neglect, domestic abuse, alcohol and substance misuse, and a historic criminal investigation of child sexual abuse by N's stepfather.

Learning themes include: the assessment of risk, need, and parental capacity; communication between and within agencies; the voice of the child; intervention threshold criteria; and identifying and responding to intrafamilial child sexual abuse.

Recommendations to the partnership include: ensure statutory assessments by children's social care consider information from all agencies who know the family and the nature of the concerns; clarify the pathway when a child is not brought to medical appointments; ensure flagging systems are understood across all agencies; seek assurance that in cases of domestic abuse, all agencies can add a flag to the record of the person who has harmed; ensure all strategy discussions meet statutory guidance and include all relevant partners; seek and obtain children's voices through methods appropriate to their age and level of understanding; ensure children's voices are given weight and consideration alongside those of adults; ensure all agencies understand the partnership escalation policy; and promote best practice in cases where a child has suffered or is at risk of suffering sexual abuse.

Other resources Read practice review (PDF)

4. Local Child Safeguarding Practice Review: 'William' for Kent safeguarding children multi-agency partnership

Serious injuries to a 22-month-old boy in March 2022 whilst at home with his family. His mother and her partner were arrested after the incident. There was a history of domestic abuse and contact with services in the wider maternal family.

Learning themes include: early identification and referral; consideration of family history; understanding the lived experience of children in the family; assessment practice - understanding risk in the family, including domestic abuse and parental mental illness; multi-agency collaboration and communication; and the practice of flagging hazards on case management systems to identify perceived safeguarding risks.

Recommendations include: all agencies should ensure that available family records are reviewed at the point of referral and allocation to establish any known family history of risks or vulnerabilities; the partnership and partners should consider how best to re-engage GPs with other key professionals working with children and families in a meaningful relationship-based way, rather than relying solely upon the exchange of electronic information-sharing; guidance for improved multi-agency planning should be offered to all of those working alongside families; and partners should review arrangements across the different agencies for flagging safeguarding risks, and if required, devise a process for the sharing, flagging and reviewing and removal of risk identifiers to ensure that children are as safe from harm as possible.

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

5. The Manning Family Child Safeguarding Practice Review: Summary report

Serious incident in April 2023 involving a boy in possession of a phone with indecent and sexual abuse images of children. Oliver was one of six siblings aged between 7-19-years-old at the time of the incident. All children had additional needs.

Learning explores: race, ethnicity, adultification and cultural considerations within professional decision making; understanding of, and response to, risk; voice of the child; acting on indicators of harm; drift and delay; and escalation.

Recommendations to the partnership include: ensure that all agencies adopt culturally competent, responsive, and sensitive practices in their assessments and interventions; ensure the professional inter-adultification model is implemented within individual agencies safeguarding training, supervision and assessment; undertake a joint SEND small sample audit with children with disabilities (CWD) and share learning within the services; collaborate with the Autism Resource Centre to develop a joint mental health protocol; review cases with CWD where chronic neglect is a concern to identify any that meet the significant harm threshold and require escalation; review the research and findings from the NSPCC 'Too little, too late' neglect report to devise an implementation plan; seek assurance from the police that victims and survivors of domestic abuse are provided with referrals to local specialist support services; with the housing association determine if there is a framework for the joint management of 'unseen' children and families and develop one if necessary; develop a 'Think family' guidance protocol and checklist; and provide joint multi-agency HSB and neurodiversity training to support professionals with identification and referral.

Other resources Read practice review (PDF)

6. Report of the Child Safeguarding Practice Review regarding C110, C111, and C112

Death of a 3-month-old girl in April 2024 after being left asleep on the family sofa. Cause of death is believed to be sudden unexpected death of an infant (SUDI), however, further medical examinations identified healing fractures to C110 and possible healing fractures to her twin, C111. Both parents remain under investigation for grievous bodily harm.

Learning themes include: understanding 'additional needs' when delivering safer sleeping advice and barriers to following this advice; assessing the strengths and potential risks from male carers; supporting care experienced parents; and responding to incidences of missed antenatal appointments and babies not being brought to appointments.

Recommendations to the partnership include: consider an expansion of the current 'prevent and protect' model to take in the 'additional needs' identified in the 'SUDI continuum of need' including the demands of caring for twins; seek assurance that closures of early help plans include contingency planning, and clear pathways are in place for families that may need to be re-referred into early help services; ensure practitioners are aware of the potential risks and vulnerabilities that could impact parenting for care experienced parents; review the current way that ICON information is delivered to parents and co-parents, especially those with additional vulnerabilities; consider adding the engagement and assessment of 'hidden males' as a business priority.

Actions for the NHS Trust include: ensure compliance with safer sleep advice is carried forward in any assessments regarding future pregnancies; ensure staff in delivery suites and assessment units ask routine domestic abuse enquiries; and consider amending local recording systems to ensure that missed appointments are flagged.

Other resources Read practice review (PDF)

7. Extended Child Practice Review: CVSB CPR 07/2018 (Child G)

Removal of a girl from parental care in September 2018 following extreme sexual behaviour in school and allegations of intrafamilial and extrafamilial child sexual abuse. Child G had been known to services since she was an infant due to concerns including domestic abuse, child sexual abuse, and poor home conditions. Concerns had also been raised about Child G's sexualised behaviour, distressed and disruptive behaviour, poor hygiene and poor nutrition since early 2017.

Learning themes include: the voice and lived experience of the child; professional curiosity; multi-agency working and information sharing; long term work with families; and record keeping and policy development.

Recommendations include: support professionals in understanding the daily experiences of children, including their family history and the role of adults in their lives; promote knowledge of how to recognise and respond to child sexual abuse; ensure that risk-assessment and decision-making considers factors including the wider family context and any previous referrals; support practitioners in identifying and responding to uncooperative behaviour when working with families; ensure information is shared using appropriate channels and all safeguarding concerns are appropriately reported; continue to review and promote protocols around escalation and resolution in cases of professional disagreement; continue to develop record keeping practices

across the partnership, including producing a guidance document; and consider making analytical multi-agency chronologies available to individual agencies.

Other resources Read review online: cardiffandvalersb.co.uk/safeguarding-reviews/

8. Local Child Safeguarding Practice Review: Child V

Death of a 7-year-old girl unexpectedly in January 2023. Child V had complex health needs and disabilities and, in the years, preceding Child V's death, there had been significant contact with both health and social care practitioners. This related to the provision of support in meeting Child V's health needs and long-standing concerns about neglect.

Learning includes: insufficient focus on the cumulative harm that Child V was being exposed to meant that risk was never fully understood or agreed across the multi-agency network; insufficient management grip, knowledge deficits and the significant number of services involved with Child V meant there was an ambiguity about risk, case ownership, roles, responsibilities and communication; the main inhibitor to effective engagement in this case was Child V's father; the priority afforded to Child V's needs was diluted by repeated attempts to influence a change in parental behaviours; and care proceedings were neither timely nor effective in bringing about a material change for Child V.

Recommendations include: safeguarding partners should seek to strengthen their arrangements for how neglect is understood, identified, assessed and planned for across the partnership; the local authority and NHS should review the effectiveness of its arrangements governing multi-agency practice with children with disabilities and complex health needs; and the partnership should issue practice guidance and review its offer on delivering local multi-agency training aimed at working with parents/carers where their engagement is reluctant or sporadic.

Other resources Read practice review (PDF)