NSPCC Repository June 2025

The NSPCC added eight case reviews to the repository featuring issues including emotional abuse, child neglect, cultural competency, and children who have disabilities.

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: Child H

Death of an 11-year-old girl. The postmortem linked H's death to her life-long health condition and poor control of this. This finding has been challenged by the team treating H. On the day of H's death, her home environment was found to be very poor and unclean. The other children in the house were removed and the adults arrested on suspicion of child neglect, but no charges have been brought.

Learning themes include: illness and death of a parent; managing a child's health needs; kinship care and parental responsibility; home environment; physical and mental health needs of adult family members; and intersectionality.

Recommendations to the Partnership include: offer support to families of children with serious health conditions in a way that mitigates barriers to accessing help and understanding information; develop public health messaging which encourages families to seek support when a child is diagnosed with a serious health condition; provide appropriate training to all family members involved in delivering a child's health care plan; review the cultural competence of bereavement support services; support professionals in helping families to access bereavement support services and in responding when this support is refused; ensure information about informal kinship care arrangements is shared with families in an accessible way that they fully understand; review the circumstances and thresholds for home visits from relevant agencies; ensure training and guidance for housing staff includes responding to home conditions that could be harmful to children; and ensure intersectionality and anti-discrimination are embedded in training and practice.

Other resources Read practice review (PDF)

2. Local Child Safeguarding Practice Review: Henry

Hospitalisation of a 3-year-old boy with life-threatening injuries in December 2022. Henry's mother and her partner pleaded guilty to causing or allowing serious injury to a child in Autumn 2024. Henry's mother had been known to services for several years due to concerns including her own

childhood emotional, physical and sexual abuse. Henry was subject to a supervision order, child arrangement order and child in need plan between 2020 and 2021.

Learning themes include: the impact of adverse childhood experiences on parenting and relationships; trauma-informed practice; parental engagement with services; unseen men; domestic abuse; assessing the risk of child physical abuse and neglect; safeguarding children when a sibling has already been removed from parental care; cross-border cooperation; missing children; and information sharing.

Recommendations to the Partnership include: promote awareness and understanding across all agencies on areas including effective case handover, the impact of parental eating disorders, signs of parental disengagement, and the impact of a Traveller or Roma background and families' transience; ensure children's social care assessments fully include partners who live at or visit a child's home; review any child protection plans and support after a domestic abuse event takes place; ensure case closure is discussed with all relevant agencies and professionals; ensure parents can fully understand all documents provided to them; ensure intensive visiting when a child is first returned to their parent's care; include contact details for all relevant professionals on nursery registration forms; and review local arrangements for the public to make anonymous child protection referrals.

Other resources Read executive summary (PDF)
Read practice review (PDF)

3. Child Safeguarding Practice Review Executive Summary: Child U

Death of a pre-school aged child from traumatic head injuries in May 2020. Child U was a child of Asian nationality and came to England in 2019 with someone who claimed to be their adoptive mother. Child U lived with, who they considered to be, their two older siblings, mother and father, none of whom were biologically related to them. A new baby was born three days before Child U died. The family were known to several agencies, including a local GP, local community health visiting service, acute midwifery service, a school, a nursery, a mental health charity and the British Red Cross (BRC).

Learning themes include: domestic abuse and its impact on children; cultural competence; working together, services' capacity, and demand; father inclusive practice; establishing parental responsibility; and the impact of COVID-19. Highlights action already taken by the Partnership since the incident.

Further recommendations include: create an easy reference document, with links to training and guidance on key issues identified within the learning; and share the new multi-agency risk assessment conference (MARAC) process to all agencies once the dedicated MARAC launch edition newsletter has been published.

Other resources Read executive summary (PDF)

4. Child Safeguarding Practice Review Summary Report: Mara

Suspected child sexual exploitation (CSE) of a 15-year-old girl in November 2022. Mara was found with two adult males after going missing from foster care. Mara also alleged physical and sexual assault from her foster carers. Mara has a genetic condition, atypical autism and additional needs.

Learning themes include: information sharing and multiagency response, including delays, strategy meetings, record-keeping, escalation, cross-jurisdictional issues, and specialist expertise; professional curiosity and voice of the child; interventions and support around child exploitation, sexual assault, personal and cultural identity, and life story work; input from adult services; deprivation of liberty and restrictions; risk assessments; transition planning; and placement sufficiency.

Recommendations include: develop multiagency guidance and a workplace development offer regarding effective strategy meetings and S47 investigations; develop an inter-agency escalation monitoring and thematic learning framework; develop a multiagency workforce development offer to enable recognition of when children may be experiencing deprivation of liberty and raise awareness of need to seek legal advice; develop regional safeguarding pathways and practice guidance to support children who are neurodiverse and/or with additional needs and at risk of CSE; implement a multiagency workforce development offer to increase awareness of independent sexual violence advisor support services; undertake targeted practice review activity to provide assurance of enhanced independent reviewing officer (IRO) oversight, support and challenge of direct work and life story plans for children; and develop guidance to ensure involvement of adult mental health services in supporting children in care who have contact with parents that are receiving mental health support.

Other resources Read practice review (PDF)

5. Local Child Safeguarding Practice Review: Kyle and siblings

Death of a 1-year-old boy in October 2020. Kyle drowned when he was left in the bath with his sisters (aged 5 and 2-years-old) without adult supervision. The parents were convicted of neglect. 17 referrals of concerns were made by professionals and people in the community about siblings Rea and Lena, and for Kyle when he was born.

Learning themes include: responding to referrals of concern including those made by people in the community; addressing child neglect; the response to domestic abuse; invisible men and the extended family; and recognising a child's lived experience.

Recommendations to the Partnership include: seek assurance from the Advice and Guidance Service (AGS) that records of decisions and outcomes are always sent to referrer in a timely way; ensure professionals understand and operate within the AGS model, and understand the escalation process; ensure that AGS are making decisions based on an understanding of family history, repeat referrals in a short time frame, evidence of cumulative harm and lack of change; review the extent to which AGS professionals rely on self-reporting from parents in making decisions; seek to

understand any barriers to use of the Graded Care Profile in practice; ensure that all professionals are aware of the importance of discussing domestic abuse with victims/survivors in safe and appropriate ways; remind social workers of the importance of using family group conferences, especially in the context of an early help response and child in need processes; ensure professionals always document children's lived experience; and devise guidance to share public health messages regarding water safety for children.

Other resources Read practice review (PDF)

6. Extended Child Practice Report: Child X and Child Y

Sexual abuse of two adolescent boys by their foster carer (Adult Z). Child Y disclosed the abuse in April 2020. Child X disclosed the abuse in March 2021. Adult Z was found guilty of the sexual assault of Child Y, but not guilty of the charges in respect to Child X. Both children had been subject to significant adverse childhood experiences prior to their placements with Adult Z.

Learning themes include: child vulnerability, especially that of children in care; the risks of developing a narrative about/around a child; children's wishes, feelings and lived experiences; placement planning and matching; monitoring and reviewing a child's placement; the assessment of suitability to foster; the supervision of foster carers; alcohol use by children and foster carers; use of technology; identifying and responding to concerns of harm; people in positions of trust; the parental responsibility and role of foster carers; and abuse disclosure.

Recommendations to the Partnership include: review policies and processes around the recruitment, review and supervision of foster carers, focusing particularly on foster carer supervision and record keeping, managing allegations against foster carers, and placement planning and matching; ensure the voice of the child is captured in placement supervisions and annual reviews; review the content and availability of safeguarding training for all Partnership staff; ensure training for fostering services includes how to manage allegations and concerns about people in positions of trust; and review the thresholds for information sharing when police have attended an incident at a fostering household.

Other resources Read review online: cysur.wales/child-practice-reviews/published-child-practice-reviews/

7. Local Child Safeguarding Practice Review: Child WS

Death of a 6-year-old-boy in summer 2020. The child's father plead guilty to gross negligence manslaughter in 2025. Child WS had numerous complex medical needs and significant developmental delays. His family had been known to services due to concerns including parental mental health issues, use of physical punishment, and domestic abuse.

Learning themes include: hearing the voice of and safeguarding a child with complex disabilities; understanding the culture and parenting practices of minority ethnic families; building

relationships with parents, including exploring parents' history of trauma; working together to support children with disabilities; information sharing between and within agencies; understanding the role of men in a child's life; responding to families who do not engage with services after a child protection plan has been stepped down; and including housing in child protection cases.

Recommendations to the Partnership include: ensure all relevant agencies contribute their assessments and recommendations to education health and care needs assessments and reviews; share occupational therapy assessments pertaining to children with disabilities with parents and all relevant agencies; develop a joint protocol between occupational therapy, housing, and children with disabilities services regarding assessments of children with disabilities; issue multi-agency guidance for escalating concerns following a step down from child protection plans; ensure steps are outlined for responding to increased risk or parental disengagement after a child protection plan has been stepped down; and consider extending partnership training on cultural competency, including building relationships and trust with families from minoritised ethnic backgrounds, and on the safeguarding needs of children with disabilities.

Other resources Read practice review (PDF)

8. Local Child Safeguarding Practice Review: Finley

At the end of 2021, police attended the home after receiving a 999 call from a family member reporting that Finley's father appeared to be suicidal and had said that he had killed his 5-year-old son. Finley was found and taken into police protection and placed with foster carers. Finley experienced emotional harm and neglect over a long period in the care of his father.

Learning includes: the practice in the case sometimes lacked sufficient focus on Finley; there was an over-focus on the father's needs; there was a need for more focus on the quality of Finley's lived experience and on father's lack of openness and cooperation; identified risks to Finley were not always fully investigated or considered; there was not a robust multi-agency approach in practice or in the child protection processes; lack of assessment, planning and action.

Recommendations include: joint guidance should be commissioned to direct how children's and adult mental health services work together; all child protection conferences must be formally minuted; there must be robust evidence for ending a Child Protection Plan and that all agencies attending the child protection conference are in agreement with this; when children move from pre-school to primary school, there should be a system in place for ensuring that the safeguarding records of each child are transferred with them and shared with the school; and there is need for all agencies to ensure that when children have suffered significant harm, all evidence is collated in a timely way.

Other resources Read practice review (PDF)