NSPCC Repository July 2025

The NSPCC added six case reviews to the repository in July featuring issues including suicide, placement breakdown, non-accidental injuries, and housing

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: Child A

Death of a 3-year-old boy in early 2020. Proceedings were initiated at the end of 2022 to remove 3-month-old Sibling B from parental care due to concerns including neglect and poor living conditions. In December 2022, the parents disclosed that they had buried Child A's body in the garden of their former home. Both parents were convicted of causing or allowing the death of a child, and of perverting the course of justice. The family had been known to services since March 2015. Concerns included not engaging or engaging late with antenatal care, parenting capacity, homelessness, and neglect.

Learning themes include: working with race, ethnicity, culture and beliefs; understanding parents' resistance to engaging with professionals; the impact of coercion, control, and grooming; assessing risks to children; relationship-based practice; children's lived experiences; and access to universal services.

Recommendations include: all partnership areas involved to examine current multi-agency guidance, particularly regarding children who become hidden from professional sight or whose parents choose to live an alternative or off-grid lifestyle; Birmingham Safeguarding Children Partnership (BSCP) to benchmark local strategies, policies, procedures, and practice against all recommendations and questions in the Child Safeguarding Practice Review Panel's 2025 report on race, racism and safeguarding; and BSCP to review practice guidance and pathways for child at risk of hidden harm, such as in cases involving late pregnancy booking, home births, refusal of routine childhood immunisations or medical interventions, dietary restrictions for both child and parents, missed health appointments, coercive control, and professionals encountering parental aggression.

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

2. Local Child Safeguarding Practice Review: Princess

Details the care experience of Princess. Due to an escalating pattern of behaviour and missing episodes Princess's parents said they could no longer cope, and she was placed in temporary foster care with parental agreement.

Learning explores: understanding a child's need and experiences; the impact of risk; missing episodes and deprivation of liberty orders; the use of restraint; finding and maintaining a suitable placement; unregistered placements; therapeutic and behavioural interventions; and multi-agency partnership working.

Recommendations to the partnership include: assure itself that all relevant agencies have policy and guidance in relation to the use of restraint; the local authority (LA) should prioritise ensuring it has access to the full range of placement options, including in house residential care, keeping children closer to their homes and maximising the likelihood of a safe return home; relaunch the resolving professional differences policy, ensuring it is fully inclusive, irrespective of role or status, including the option to commission an independent person as facilitator in complex cases; review the effectiveness of its working relationships in achieving its statutory goals; agree a process for ensuring a prompt multi-agency managerial response to complex cases resulting in a child's fundamental needs not being met and include an agreement when, how and by whom this should be triggered; ensure all partners have robust policies and procedures in place for supporting staff welfare which meet the needs of all employees; and explore options for sharing learning, and opportunities for collaboration, across the partnership regarding the support of staff welfare.

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

3. Joint Child Safeguarding Practice Review: Child Yue

Suicide of a 16-year-old girl in 2023. Yue had come from overseas to attend a UK boarding school the previous September and had completed Year 12. The coroner found that she had taken her own life, using prescription medication from her own country. Yue was attending an 'out-of-education' work experience placement at the time.

Learning themes include: the response to an international student's mental health diagnoses and treatments; information sharing; working across agencies to respond to risk; the role of education guardians and homestay hosts in the lives of international students; and the safety of out-of-education residential programmes.

Recommendations include: where a child has a mental health diagnosis, admission meetings should include a mental health lead in the school; all residential students should be registered with a local GP and prospective parents should be aware of this; students who arrive with symptoms or a diagnosis of mental health conditions should be assessed under the supervision of a UK-based clinician, and treatment regularly monitored; school nursing staff should receive clinical and safeguarding supervision; all adults involved in the care of an international student with additional needs should be included in regular multi-disciplinary communications to reflect on the child's progress; schools should be aware of DfE non-statutory information-sharing advice and its relevance to safeguarding practice; and prior to coming to the UK a child should meet their appointed education guardian at a (virtual) meeting. The DfE should: make the regulation of education guardianship statutory through national minimum standards for the sector; revise statutory guidance so that education guardianship and homestays are considered as positions of trust; and implement statutory regulations across the out-of-education sector.

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

4. Local Child Safeguarding Practice Review: Baby A

Non-accidental injuries to a 3-week-old baby girl. Injuries indicated that she had been shaken or thrown. Baby A was living with her parents at the time of the incident. An Interim Care Order was granted to safeguard Baby A whilst a criminal investigation was ongoing.

Learning themes include: lower-level parental mental health issues; early engagement of fathers; coping with crying babies; use of Hospital at Home; differential diagnosis in apparent life-threatening events (ALTEs); and escalating professional disagreements.

Single agency action plans have already addressed recommendations regarding the awareness and benefits of professional challenge and how to escalate concerns, professionals attending mental health awareness training, and professionals accessing the ICON30 training and providing information about safe handling and shaken baby syndrome to expectant and new parents.

Further recommendations to the Partnership include: consider how a procedure for ALTEs and sudden unexpected death in infants and children (SUDICs) can be consistent across the region and raise the lack of national ALTE guidance with the Child Safeguarding Practice Review Panel; and consider undertaking a thematic trend analysis to explore themes that are potentially common in other cases locally.

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

5. Child Safeguarding Practice Review: Olivia

Rape of a 17-year-old girl by two men in March 2022. From 2019, there were concerns around multiple missing episodes, child exploitation, disclosures of sexual abuse, substance use, and physical assaults committed by and to Olivia. Olivia experienced multiple placements, including time in secure accommodation. Olivia has an ADHD diagnosis.

Learning themes include: trauma-informed approaches and adultification; multiagency response to risk; disruption activity against perpetrators of child exploitation; social media; placement sufficiency; permanency planning; interventions and direct work regarding substance use, independent advocacy support, health, education and therapeutic needs, secure accommodation, and sequencing; transitions; and Covid-19.

Recommendations include: the partnership to undertake quality assurance exercises regarding children who have experienced multiple instances of rape and sexual assault; police to review interface between child exploitation teams and serious organised crime units regarding cooperation on cross-jurisdictional intelligence sharing and coordinated disruption; the partnership to develop and integrate a child exploitation disruption workforce development offer to enhance knowledge and use of the Home Office disruption toolkit; the partnership to develop clear guidance and workforce development offer around safe, effective engagement with social media when safeguarding children at risk of extra-familial harm; the partnership to undertake quality assurance activity regarding transfer of GP and health records for children in care who are mobile across local authority areas; and children's social care to undertake quality assurance activity and workforce development programmes to enhance care planning for children in care at risk of child exploitation.

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

6. Local Child Safeguarding Practice Review: Laura

Death of a 20-day old baby in 2023. Laura's family were being supported by early help services in Medway at the time of her death. In the past, the family had been subject to court proceedings,

child protection and child in need planning, and had moved housing at least 14 times in the previous seven years.

Learning themes include: the impact of multiple house moves and homelessness on children's wellbeing and education; the challenges of cross borough working to safeguard children experiencing chronic neglect; identification, referral and assessment of need and risks in pregnancy; assessing the needs of children (including the unborn) and their lived experience.

Recommendations to partnership agencies include: assure themselves that robust systems are in place to ensure that fathers and other significant males are actively considered in assessments and ongoing work with families; ensure robust liaison between midwifery services and GPs for pregnant women, including reviewing and modifying current systems to ensure that there is an exchange of information about both parents (and partners); issue reminders to practitioners and managers about the importance of following the established multi agency procedure for the pre-birth assessment pathway; review relevant protocols to ensure effective joint working, especially where housing issues are identified as an additional need (e.g. where it is causing interruption to services) or are integral to children's protection; and ensure professionals are equipped with the knowledge and understanding of intersectionality to properly identify and consider children who experience multiple oppressions and disadvantage when assessing and managing risk.

Other resources Read practice review (PDF)