NSPCC Repository September 2025

The NSPCC added six case reviews to the repository in September featuring issues including child criminal exploitation, domestic abuse, filicide, and child neglect

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: Gabriel

Death of a 17-year-old boy in November 2022. Gabriel died during an altercation with two young people, one of whom later pleaded guilty to manslaughter. Gabriel had been subject to substantial agency involvement between 2016 and 2022. Gabriel was sentenced in 2022 for offences committed around three years earlier, when he was 13 years old.

Learning themes include: the voice of the child; the impact of ethnicity, culture and religion; identifying young people at risk; the assessment of risk; providing support to parents; and the impact of coronavirus.

Recommendations to the partnership include: emphasise the importance of holistic family assessment as the basis for effective early intervention with families with complex needs; ensure processes are in place for escalating and resolving professional differences, in particular regarding threshold criteria and levels of need; ensure up-to-date case summaries and histories are provided when a case transfers to another local authority; in training on work with vulnerable adolescents, highlight the ease with which risks travel across local boundaries; continue to prioritise the integration and co-ordination of multi-agency arrangements to combat child exploitation and serious youth violence; review processes that involve the application of risk gradings for young people at risk of exploitation and serious youth violence; support professionals in recognising the significance of young people's experience at school; support professionals in delivering relationship-based work with young people; and ensure frameworks and approaches to whole family work are in place across the partnership.

Other resources Read practice review (PDF)

2. Child Safeguarding Practice Review: Overview report and addendum report: Child Theo

Death of a 7-month-old infant girl in September 2019. The investigation into the circumstances continues at the time of writing. Before Alice was born, concerns were expressed by safeguarding professionals for her and her older (11-month-old) sibling, due to a history of domestic abuse from mother's former partner.

Learning explores: decision-making; home visiting; needs assessments; cross border working; restraining orders; and professional disagreement.

Recommendations to partnership agencies include: home visiting policies should include a risk assessment highlighting the importance of staff welfare, and an expectation for the visit to include seeing the children; consider if staff are aware of steps to be taken if a restraining order is breached, including where to record it, how to secure evidence and which agencies need

informing; children and family assessments, strategy meetings and section 47 enquiries should include an understanding of significant prior relationships and children from other relationships to assist decision making; discharge planning meetings should consider vulnerable children who have been part of child in need (CiN) or child protection (CP) plans; when a supported family transfers to another local authority, especially for short periods, policies should be in line with the 'Transfer of children subject of child protection plans across local authority boundaries procedure'; safeguarding leads should review the policy and procedure around information sharing and reporting a crime, ensuring that relevant staff have received sufficient training and are confident around the importance of when and how to share information; and consider issuing advice on the length of time it takes to get care proceedings to the family court.

Other resources Read practice review (PDF)
Read addendum report (PDF)

3. Child Safeguarding Practice Review: Child W OSCP 2021

Death of a 5-year-old child in 2021 whilst in the care of his mother. Child W had significant bruising to face and body, and toxicology revealed a fatal dose of antidepressant medication in his system. Child W's mother was subsequently convicted of murder. Child W had been subject to child in need planning as an infant due to concerns around lack of parental supervision. There were also concerns around developmental delay, failure to thrive and conditions in the family home.

Learning considers: child in need planning including step-down; perception of anonymous referrals; quality of assessment; professional curiosity, challenge and support; and the impact of Covid-19.

Recommendations include: review and refresh guidance on responding to anonymous referrals and ensure this is part of the MASH operating procedures; the partnership create a challenge event which requires partners to review and identify ways to improve the engagement of all parents in exercising their parental responsibility; and ensure that professionals develop strong critical thinking skills as a foundation to supporting professional curiosity and robust judgement.

Other resources Read practice review (PDF)

4. Domestic homicide review incorporating a local child safeguarding practice review: Elizabeth

Elizabeth was found deceased at her home address in late 2019. Elizabeth's partner of two years, John, was arrested and charged with her murder. Elizabeth was the mother to six children, five of whom lived with her. John was the father to the two youngest children. Elizabeth and her children were known to children's social care from 2013. Concerns were linked to domestic abuse, alcohol misuse and Elizabeth's mental health.

Learning themes include: information sharing between agencies; accurate recording and verifying of household members; and awareness of domestic abuse, including coercive control.

Recommendations to the community safety partnership include: all agencies should provide evidence that accurate information, including exact details of disclosures and the voice of the child are being shared between agencies where safeguarding concerns are known; all agencies should provide evidence that professionals are adopting a 'trust but verify' approach when working with families, which includes the accurate recording and verification of all household members and significant others to inform assessment and risk planning; all agencies should provide evidence that professionals are aware of the full extent of the definition of domestic abuse, in terms of 'family

members' and are implementing safeguarding policies where incidents of domestic abuse are known; and ensure that the domestic abuse strategy details how it will respond to the cultural acceptance of domestic abuse and improve the confidence of victims and witnesses to report abuse. Also details all single agency recommendations.

Other resources Read practice review (PDF)

5. Child Safeguarding Practice Review: Aiden

Suicide of a 16-year-old boy. Aidan's family were involved with universal services and learning disability (LD) CAMHS at the time. There had been periods of intervention and support at early help, children in need (CIN), and threshold for child protection.

Learning themes include: lived experiences of cumulative neglect and its impact; multi-agency working including thresholds and decision making; and recognising and responding to suicidal ideation.

Recommendations to the partnership include: seek assurance that multi-agency assessment, history, and analysis directly inform decision-making about the threshold for intervention where neglect is a key feature; ensure practitioners are supported in developing critical thinking by providing space and time to access case information to help them understand the family history; ensure that multi-agency practitioners and managers have strengthened knowledge and guidance about adolescent self-harm and suicide in relation to the coexistence of neurodiversity, learning disability and neglect and that there are effective pathways for identifying vulnerable adolescents with risk factors; ensure partners promote leadership that models critical thinking and safe, professional challenge across the multi-agency space; promote and seek assurance that cross-boundary systems and practices across the partnership footprint are collaborative and meet the needs of vulnerable children and families; seek assurance from CAMHS that information they hold about children's mental well-being and progress is shared with key professionals to inform risk assessment and support; share and regularly update safety planning for children with suicidal ideation with the family and the wider professional network; listen to the views of parents /carers to strengthen service and practice improvements with regards to communication and support.

Other resources Read practice review (PDF)

6. Child safeguarding practice review: Children L

Neglect of a sibling group by their parents in the context of a perplexing situation. Children L became subject to child protection planning processes in August 2020 and were placed into foster care in February 2023. From a few months old, Children L all followed the same trajectory with reports of developmental delay, a range of confusing physical and psychological health presentations and poor school and/or nursery attendance.

Learning themes include: understanding a child's world in situations of neglect; assessment - working out perplexing presentations and measuring the quality of care; 'Think family' - understanding causal factors and helping parents; effective plans which show impact for children; and escalation and challenge across partnerships.

Recommendations for system change include: the partnership to develop a multi-agency neglect strategy and framework, which includes a published toolkit to support professionals when assessing situations of neglect at all levels of need and a communication strategy to consider how the strategy/framework/toolkit is rolled out to agencies; and multi-agency professionals from the

partnership to work together to develop and embed a localised multi-agency perplexing presentation pathway to enable effective and timely escalation of situations of concern and to include a definition of the role of the responsible clinician. **Other resources** Read practice review (PDF)