

NSPCC Repository

October 2025

The NSPCC added eight case reviews to the repository in October featuring issues including parental mental health, racism, sudden infant death, 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. Child Safeguarding Practice Review: BSCP 2022-23/03

Death of a 3-week-old boy in Autumn 2022. The baby's father caused his son's death during a sudden mental health crisis. Prior to the baby's death the family were receiving universal services and were not known to children's social care or mental health services.

Learning focuses on: services' responses to calls regarding the deterioration in a person's mental wellbeing; responses when a person presents at hospital in mental health crisis, and if a person leaves hospital without assessment; the impact of resource and demand pressures on service responses; support or advice provided by places of worship; understanding a family's response to the decline in a family member's mental wellbeing; and equity, equality, diversity and inclusion.

Recommends that the National Child Safeguarding Practice Review Panel considers whether this report reflects wider issues affecting the safety of children affected by parental mental ill health, including where the parent is not known to services but there is a sudden and urgent mental health concern.

Recommendations to the Partnership include: implement national guidance regarding how best to respond to people in a mental health crisis; explore whether gaps in the understanding of professionals regarding different faiths or cultures reflects experiences in other reviews, and develop staff's cultural awareness if this is so; and consider how the existing programme of engagement and training for faith leaders can be developed to enable all places of worship across the city to have access to and undertake safeguarding training and specifically mental health first aid training.

Other resources [Read practice review \(PDF\)](#)

2. Local Child Safeguarding Practice Review: Child Zeta

Death of a 17-year-old boy in October 2023. Another adolescent boy was charged with the murder of Child Zeta. Child Zeta was well known to agencies including the police, youth justice service, and children's social care. There were significant concerns including child criminal exploitation, drug use, and mental health problems.

Learning themes include: understanding knife crime and the carrying of knives as a safeguarding issue; strategically disrupting child criminal exploitation and serious violence; considering a defendant's safety when exploitation is a potential factor in criminal proceedings; sharing and using information across local authority boundaries; and barriers impacting asylum-seeking and refugee children from racialised backgrounds.

Recommends that relevant national services consider producing guidance for lawyers regarding what to do with information which raises a safeguarding issue for a client who is a child.

Recommendations to the Partnership include: ensure plans and assessments include information about why a child is carrying a knife and the measures in place to reduce the need for them to do so; review the impact and effectiveness of the local pilot police operation regarding cases involving children at risk of modern slavery; when children and young people are placed out of area, ensure risk assessment and planning remains child-centred and addresses each area's interpretation of risk; explore, record, and integrate into plans the role of social media in the lives of children involved in or at risk of criminal exploitation; and support practitioners in exploring the lived experiences of people from differing religious, cultural and political backgrounds.

Other resources [Read practice review \(PDF\)](#)

3. Local Child Safeguarding Practice Review: Baby C

Death of a 7-month-old boy in February 2022. Baby C's mother pleaded guilty to manslaughter. Prior to his birth, Baby C had been placed on a child protection plan under the category of neglect. This was because his mother's three older children had been removed from her care. One week before his death, Baby C had been moved to a child in need plan. Baby C's mother had a history of service involvement due to concerns including domestic abuse, mental ill health, drug misuse, homelessness, and experiencing significant childhood trauma.

Learning themes include: information sharing across local authority boundaries; ensuring the accuracy of information and records; exploring historic and current risk factors; understanding cumulative harm; handing over cases within and between agencies; assessing home conditions; core group membership; professional challenge and scrutiny; decision-making; case recording; and unseen men.

Recommendations to the Partnership include: explore ways of improving cross-boundary information sharing; update local protocols to include cross-boundary working processes; support frontline practitioners in understanding their individual and collective role in multi-agency work to safeguard children; ensure standards for reflective discussions and supervision are embedded in policies across all agencies; ask agencies to review their handover processes to ensure a continuity of understanding; ensure all partners have processes in place to share information with all relevant agencies; roll out the refreshed home environment assessment tool and family engagement tools; and audit the use of these refreshed tools across all relevant agencies and case files.

Other resources [Read practice review \(PDF\)](#)

4. Local child safeguarding practice review: Child H

Death of a 2-year-old girl in August 2023. Child H was a child with disabilities who died after choking on a small piece of plastic at home. Child H's family faced significant pressures and challenges, particularly regarding housing and mental health.

Learning themes include: understanding the child's daily lived experience; understanding and addressing complex family relationships and vulnerabilities; and multi-agency safeguarding responses.

Recommendations to the partnership include: ensure that children who have disabilities are consistently recognised as children in need (CiN) and amend the electronic case recording system to remove the ambiguity of 'CiN features'; ensure that children's safety plans are written (unless in

an emergency) and of good quality using a standard format; multi-agency working, especially the expectation of meetings and plans, should be embedded across the safeguarding system at all levels of need; all staff should be encouraged to initiate multi-agency discussions in order to share information; ensure that case audits include regular reviews and reflection on the quality of management oversight; design and implement a format for recording the needs of children with complex health needs and disabilities so that there is a single, easily sharable record of a child's condition(s), treatment, and daily routines; ensure that the Graded Care Profile 2 is routinely used where there are concerns about aspects of care or the home environment which need to be assessed and monitored; review the Neglect Screening Tool and consider amending it or replacing with another evidence based tool; and review the availability of paediatric first aid and choking prevention training for parents.

Other resources [Read practice review \(PDF\)](#)

5. Child Safeguarding Practice Review: Hope

Severe injuries to a 6-year-old child in November 2023 after falling from an upstairs window at home. There was long-term multi-agency involvement with the family due to concerns about neglect, emotional abuse, and domestic abuse, initially involving the mother's partner and later the older half-sibling towards the mother. Hope's mother is deaf and has a chronic illness diagnosis.

Learning themes include: understanding and managing neglect; cultural identity; parental health, trauma and its impact on children's lives; domestic abuse; and supporting families who move often or are in unstable accommodation.

Recommendations to the partnership include: review its neglect strategy, focusing on proactive strategies and sustainable interventions to tackle long-term patterns of harm; ensure that its partners and organisations have anti-racist and anti-discriminatory practices in place, actively supporting practitioners to address race, ethnicity, and culture in safeguarding; review the support available to frontline practitioners for assisting parents with complex health, communication, or trauma needs; suggest a review of cases involving serious child-to-parent violence, examining the effectiveness of current interventions and identifying strategies to improve outcomes; work with the local community safety partnership to review trauma-informed interventions addressing the needs of children as direct victims of domestic abuse; evaluate transitional safeguarding mechanisms to identify gaps in support for young people transitioning to adulthood; ensure ongoing efforts to engage fathers and male caregivers in safeguarding assessments and planning are sustained; and support cross-agency collaboration to evaluate multi-agency protocols for families in unstable housing.

Other resources [Read practice review \(PDF\)](#)

6. Learning from the Oak Review

Serious incident involving an assault on a young Black person in care.

Learning themes include: hearing the voice of minoritised groups; the experience of racism and racial trauma in local communities; engaging young people in care who have experienced significant trauma; understanding the safeguarding implications of elective home education; and opportunities to develop a community-based safeguarding system.

Recommendations to the partnership include: promote inclusion and positive engagement with minoritised groups across all organisations working with children; include the lived experienced of

minoritised groups in strategy; all leaders (including governors and trustees) in education settings should complete inclusive practice training; partner agencies should build on the strategic multi-agency plan for working positively with the Gypsy Roma Traveller (GRT) communities; work with partner agencies to improve staff confidence and skills in working positively with families to safeguard children in GRT communities; children's services should set out expectations regarding actions when a child in care is suspended or excluded from school; education settings should include children in care as a specific group in any online safeguarding system; review safeguarding policies to ensure that they give sufficient guidance on integrating an understanding of elective home education into day-to-day practice; where a child who has been known to children's social care within the last 12 months is removed from school there should be an expectation of a discussion with the school, family, children's social care and the education inclusion team; and the council should consider investing in youth provision delivered in local communities focusing on wellbeing, education, and community cohesion.

Other resources [Read learning review \(PDF\)](#)

7. Child Safeguarding Practice Review Part one and Part two: Marie

Two reviews relating to one adolescent girl. Part one relates to the sexual abuse of Marie aged 9-15-years-old by her male foster carer. Part two relates to Marie's death aged 19-years-old due to drug-related misadventure. Marie and her sister had been in care since 2010 due to long-term neglect. They experienced many placement breakdowns before being placed in 2013 with the carer who became the subject of Part one.

Part one learning themes include: children in care's vulnerability to abuse and neglect; the importance of relationships between professionals and children in care; the importance of understanding and exploring a child's lived experience; and effectively challenging carers and carer behaviour.

Part one recommendations to the Partnership include: clarify response procedures for neglect concerns in foster placements; improve professional awareness of child sexual abuse and adult behaviours that indicate risk; and provide meaningful interviews for children leaving care.

Part two learning themes include: care leavers' vulnerability; the importance of multi-agency information sharing and meetings; the need for timely mental health assessments and support to care leavers in crisis; and processes for frequent users of health services.

Part two recommendations to the Partnership include: implement a policy regarding apologies and compensation following abuse by people in positions of trust; support children's services professionals in identifying and responding to adult safeguarding concerns; increase staff confidence in supporting care leavers following financial gain; raise awareness of Clare's Law; provide training and support for carers, especially relating to trauma; and offer a targeted fast-track mental health service for 18-25-year-old care leavers.

Other resources [Read practice review \(PDF\)](#)

8. Reflective Learning Document: Child V

Death of a baby in July 2021. At the time of the review's writing, police were investigating co-sleeping as a factor in Child V's death. Child V's mother had been known to a neighbouring local authority as a child. She had an unpredictable and difficult relationship with her own mother, a

history of depression and anxiety, and a diagnosis of borderline personality disorder. She had experienced a series of losses, including having a baby adopted when she was 17-years-old.

Learning themes include: the impact of adverse childhood experiences on parents; the impact of Covid-19; postnatal depression; the impact on a parent of having a child adopted; ensuring good assessments; delivering safe sleeping advice; and the risks associated with poor parental mental health.

Recommendations to the Partnership include: ensure all partners adopt a practice model which encompasses reducing the risk of sudden infant death within wider strategies for promoting infant health, safety and wellbeing; and promote in particular professional awareness of the risk of alcohol and new babies, and the need for respectful, non-judgmental care from all staff who work with patients or service users who misuse alcohol.

Other resources [Read learning review \(PDF\)](#)