NSPCC Repository December 2025

The NSPCC added eight case reviews to the repository in December featuring issues including filicide, child sexual abuse, parental substance misuse, and harmful sexual behaviour

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: Children B and C

Disclosure of sexual abuse from a 4-year-old boy in October 2023. Child B indicated he had been sexually abused by a friend of his parents, an adult male who was a prolific registered sex offender. Children B and C had older siblings who were removed from the care of their mother and father due to concerns of physical abuse and neglect in another local authority (LA) prior to their birth.

Learning themes include: children's needs and their parents' capacity to meet them; hearing the children's voices; communication within and between agencies; supporting professionals to consistently engage adults; and the efficacy of the child safeguarding system and offender management system in enabling safeguarding interventions.

Recommendations to the partnership include: ensure there is a clear training plan for relevant professionals in the Graded Care Profile 2 (GCP2); ensure that the regional work to improve the identification and response to child sexual abuse informs training, policies and procedures; ensure solo professionals such as child minders who contribute to statutory assessments are informed of the outcome; ensure escalation processes enable issues of concern, including those related to the actions of another LA, to be resolved promptly; ensure strategy discussions are convened where there is cause to suspect that a child is suffering or at risk and that they are recorded as strategy discussions in all instances, even out of hours; ask the probation service to consider that notifications about the movement of registered sex offenders are provided to the LA where the offender currently resides; and ensure that practitioners are suitably skilled to respond to adults who provide false information.

Other resources Read practice review (PDF)

2. Child Safeguarding Practice Review: Child BB

Death of a 15-year-old boy at his home in March 2021. It is suspected that Child BB took his own life, although the cause or circumstances of his death have not yet been confirmed by the coroner.

Learning is embedded in the recommendations.

Recommendations include: ensure that child sexual abuse strategy meetings consider each child and plans are drawn up accordingly; review the support available and provided to children who are regarded as a perpetrator of child sexual abuse to identify and address any gaps in the services offered to these children; ensure that relevant child protection procedures, guidance and practice

reflects the need for cases of child-to-child sexual abuse to include routine consultation with the child and adolescent harmful behaviour service (CAHBS); evaluate how far the relevant key learning from the Child Safeguarding Practice Review Panel has been implemented in practice; understand and recognise that parental conflict can have a negative impact upon children, their physical and mental health, and their wellbeing; services are available to help children, and their parents address the impact of parental conflict; information about sexualised behaviour, and appropriate responses across age ranges, is available and accessible to multi-agency partners including schools; specialist advice is sought routinely to help children with problematic sexualised behaviour as early as possible; and services involved in the care and treatment of a child with an education health and care plan (EHCP) to provide full information to inform an EHCP to ensure a child's needs are known and responded to over time.

Other resources Read practice review (PDF)

3. Local Child Practice Review: Child G

Death of a 17-year-old boy caused by cardiac arrest in June 2023. G had a diagnosis of ADHD, ASD and primary generalised epilepsy. There had been concerns about G's needs being neglected and him being at risk of sexual abuse when he was younger.

Learning themes include: the effectiveness of the assessment processes and how well agencies understood G's needs and his mother and stepfather's capacity to meet them; how well agencies heard G's voice; the communication by agencies and between agencies to safeguard G; and the effectiveness of safeguarding interventions.

Recommendations to the partnership include: seek assurance from the commissioner for school nursing services that responsibilities towards young people aged 16 plus who are in education are met so that they receive advice and support as required; seek assurance that the learning about education, health and care plans (EHCPs) in relation to bringing forward annual reviews of EHCPs when there is concern about the child, and involvement of the child's GP in the EHCP, is shared with the relevant professional agencies; consider developing a multi-agency 'was not brought' policy so that there is a shared understanding of the different roles and responsibilities and the actions to be taken when a child is not brought to a medical appointment, including for young people aged 16 plus who need support, particularly if they have learning needs; and seek assurance that when children's social care is undertaking a statutory assessment, any early help support already being provided to the child and family continues where it is appropriate to do so.

Other resources Read practice review (PDF)

4. Local child safeguarding practice review: Baby Réaltín

Non-accidental injuries to 3-month-old girl in November 2020. Réaltín's injuries indicated that she had been shaken. Réaltín had been subject to a child protection plan since before her birth. Réaltín's mother had been known to services since she was 17-years-old, due to concerns including domestic abuse incidents between her and Réaltín's father, drug misuse, and periods of going missing and being homeless. Réaltín's father had a history of domestic violence and children's services involvement in relation to his other children.

Learning themes include: registering newborns with a GP; moving from information sharing to joint analysis and decision-making; working effectively with resistant parents; using crying plans; reducing the risk of overwhelming parents; identifying parent-child bonding vulnerabilities; remote and hybrid work with families; taking a risk-based approach to transient families; multi-agency responses to 17-year-olds; taking early opportunities to complete pre-birth assessments; and understanding domestic abuse that presents as bi-directional.

Recommendations to the partnership include: review multi-agency guidance regarding information sharing and core group meetings; develop new guidance, tools and policy for working effectively with resistance; ensure all relevant staff are able to support parents and carers to develop a crying plan; ensure all assessments and plans relating to babies under 6-months-old consider the risk of abusive head trauma and parents' capacity to safely respond to their crying baby; review guidance around assessing and promoting mother-baby bonding; develop partnership protocols around hybrid working; and develop multi-agency guidance and tools to support sophisticated knowledge and assessments of relationship dynamics in cases involving domestic abuse.

Other resources Read practice review (PDF)

5. Extended Child Practice Review: Our bravery brought justice

Disclosure of sexual abuse at a school in North Wales. In early September 2023 a pupil showed staff messages and images which she reported were from the headteacher, Neil Foden. Foden was arrested the same day. Following this, other victims came forward. Foden was found guilty of 19 charges against four female pupils at the school where he was headteacher. Reviews the period from January 2017 (based on first documented incident) until 30 September 2023 following Foden's arrest and highlights missed opportunities for intervention. Also details Foden's physical abuse of male pupils.

Key learning themes include: impact of status, reputation and culture; systems and processes for reporting concerns, managing allegations and making referrals; inter-agency working; restrictive practices; governance and complaints; crisis planning and crisis response; training and curriculum; and listening to the voice of the child.

Recommendations to the Welsh Government include: ensure that the revision of Section 5 procedures is shaped by the learning from this review and are stress-tested against this case; commission a training resource based on the findings of this review for use by all schools in Wales, and ensure it is adaptable for use by other agencies working with children; initiate a review of the governance arrangements in schools in Wales; issue an addendum to the guidance on 'Reducing restrictive practices framework' (2022) around the filming of incidents by adults, and on the appropriate retention of such filmed records; and seek assurance that all local authorities have in place a strategic critical incident plan which sets out the mechanism for an immediate and coordinated multi-agency response.

Other resources Read practice review online: www.northwalessafeguardingboard.wales/gwynedd-child-practice-review/

6. Local Child Safeguarding Practice Review: Abdur

Hospitalisation of a 10-year-old boy in 2022 due to malnourishment and vitamin deficiency. At the time Abdur was a child looked after on a full care order and placed at home with his family. There is a significant history of maternal substance misuse and neglect prior to Abdur's birth.

Learning themes include: the child's voice; effectiveness of the care plan; awareness of a parent's history and the impact of substance misuse; consideration of fathers and the role of males within the home; optimistic behaviour; shared approaches to neglect; escalation processes; and challenges to court processes.

Recommendations to the partnership include: make promoting the involvement of males a key focus of its work; ensure that delivery models allow for appropriate oversight of children, especially those known to be at risk; ensure that medical/health related assessments are aligned and communicated to other agencies so that they effectively inform statutory processes and future planning; ensure care plans are effective and informed by all agency views and are strongly linked to the voice of the child; risk formulation applied in statutory meetings should be realistic, consistent, timely and reflective of a full multi-agency view; examine agency approaches to neglect, to ensure that consistent models of working are being implemented and specific attention given to those children 'placed at home'; when people 'do not engage' with services ensure agency policies are reflective of safeguarding risk; ensure that the importance of the child's voice is embedded in all procedures; review its escalation policy to incorporate supporting professionals being able to challenge colleagues within and outside their own organisation.

Other resources Read practice review (PDF)

7. Child Safeguarding Practice Review: Sara Sharif

Murder of a 10-year-old girl by her father and stepmother in August 2023. Sara, of dual Polish and Pakistani heritage, had an extensive history with statutory services; she was on a child protection plan before she was born. By 6-years-old Sara was living with her father and stepmother where she suffered prolonged abuse until her death.

Learning themes include: safeguarding processes; elective home education (EHE); working with perpetrators of domestic abuse; care proceedings and private law hearings; race, culture, religion and ethnicity; and seeking, analysing and sharing of information.

National recommendations include: safeguarding processes should ensure that any bruising to a child is properly assessed and strategy meetings held when there is likelihood of harm; all safeguarding practitioners should have good knowledge of the 'modus operandi' of domestic abuse perpetrators; work should be done with Family Justice Boards to ensure that private law is not just about family dispute resolution but recognises the risks to children; an interpreter should be available during court proceedings when a parent's first language is not English; points of difference between the advice of the children's guardian and the local authority's assessment should be recorded and summarised before the judge in respect of the care plan; the principles set out by the public law working group for the implementation of supervision orders should become expected practice in all areas; and clear role specific guidance should be developed for staff with safeguarding responsibilities. With regards to EHE the Department for Education should: review contradictions between pupil registration requirements and legislation; update statutory guidance to require a formal meeting in cases where a child has been/is known to children's social care or

the school has recorded concerns; and ensure that children are seen at home within two weeks of notification of withdrawal from school.

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

8. Thematic review: Violence affecting Black boys: How can we work better together to keep our children safe from harm outside their homes?

Thematic review concerning 14 children, mostly adolescent boys aged 14-17-years-old, involved in 11 knife related serious incidents between March 2023 and July 2024. Examines the collective experiences of the children, including three who were convicted of murder. Eleven of the children are Black British from varying heritages, and three from Asian or Middle Eastern backgrounds.

Learning considers: how interrupted schooling, previous criminal justice involvement, and special educational needs and disabilities (SEND), speech and language (SAL) difficulties, and other complex needs increase vulnerability to youth violence; adverse childhood experiences (ACEs); delayed safeguarding responses; understanding intersectionality and parental non-engagement; the role of social media in violence; transition periods and support; victim-perpetrator paradox; adultification; out-of-borough moves; quality of care at home versus contextual safeguarding; early help; and accountability across systems.

Recommendations include: enhancing safeguarding and community safety through prevention and place-based interventions; working with schools to make them safer, more inclusive, and more supportive; developing a new community cohesion and resilience team; rebuilding trust between young people and police; expanding access to youth provision and positive opportunities; strengthening mental health support with youth-centred approaches, particularly focusing on Black boys and young men; and enhancing the partnerships' collective capacity to identify, understand, and respond to risks by strengthening workforce development, intelligence gathering and the use of evidence-informed early intervention. Includes actions taken against each recommendation.

Other resources Read practice review (PDF)