

NSPCC Repository

February 2026

The NSPCC added eight case reviews to the repository in February featuring issues including extrafamilial harm, domestic abuse, private foster care, and professional curiosity

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 2021-22/02 'I was too scared to talk about the abuse' (Baby A)

Death of an 8-day-old baby girl in September 2021 whilst in the neonatal intensive care unit. Baby A was born via emergency caesarean section after her mother had attended hospital at 29 weeks pregnant with abdominal pain and bleeding. She reported that she and her partner, Baby A's father, had been carrying a cabinet upstairs when she had fallen, and the cabinet had struck her. On admission to hospital the mother was noted to have what were deemed to be grab marks to her arm. Baby A's father had previously been managed as a category level 2 violent offender.

Learning includes: the effectiveness of multi-agency public protection arrangements (MAPPA) and multi-agency risk assessment conference process (MARAC), and their interface in reducing risk and safeguarding vulnerable adults and children; and barriers to practitioners' response to suspected domestic violence where there is evidence of abuse but absence of disclosure by the victim.

Recommendations to the partnership include: share findings with the Chair of MARAC Governance to provide assurance that the learning informs the continued development of MARAC arrangements; evaluate the multi-agency safeguarding training which incorporates the outcomes, impact and quality of the professional curiosity and domestic abuse modules; undertake an audit of children's case files involving domestic abuse to evaluate the quality and impact of multi-agency intervention aimed at reducing the risk to children living in violent households; and oversee the effective dissemination of learning to front-line practitioners, supervisors, and managers within the children's workforce, including hosting a webinar, publishing a learning lessons briefing note and a training resource pack.

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

2. Thematic Local Child Safeguarding Practice Review into Serious Youth Violence

Thematic review concerning 10 adolescent boys involved in three separate instances of knife crime in February 2024, leading to the deaths of three boys aged 15-16-years-old and the serious injury of another. The children were subject to a range of vulnerabilities including belonging to minoritised communities; low levels of school attendance and multiple suspensions, moves or exclusions; undiagnosed or suspected special educational needs (SEN) and/or assessment for an educational, health and care plan (EHCP); and a history of child protection support, including experience as children in care.

Learning themes include: consistency of multi-agency responses to safeguarding children from risk outside the home; alignment and accountability across the city and cross-border; improving educational attendance and inclusion correlating to harm outside the home, and reducing preventable school exclusions and managed moves; support for children with special educational needs; co-ordinating and managing multi-agency preventative activity; and assuring an evidence-informed prevention programme for serious youth violence.

Recommendations to the partnership include: develop a whole partnership strategy for responding to extra-familial harm; review and revise all strategic, operational and direct practice panels and boards in relation to all forms of extra-familial harm; adopt multi-agency practice principles for responding to child exploitation and extra-familial harm as a whole-partnership model of working; adopt a whole partnership approach to integrating multi-agency data and intelligence in relation to extra-familial harm; implement a single multi agency child exploitation (MACE) model across all agencies (including education) as the overarching process for supporting children at risk; and establish a prevention MACE model or equivalent nested within the wider new MACE structure.

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

3. Local Child Safeguarding Practice Review: Independent Report: Child Nic

Death by suicide of a 16-year-old in September 2024. Nic had been known to child mental health services since July 2021 due to concerns including self-harm and suicide. At the time of their death, Nic was on the waiting list for an autism spectrum disorder assessment. Nic had not been in full-time education since September 2021. From at least June 2024, Nic declined treatment and denied self-harm or suicidal thoughts. During this time, Nic was accessing social media content related to self-harm and suicide.

Learning themes include: understanding the child's voice and lived experience; assessing parents' support needs; psychiatric evaluation of self-harming behaviour; education provision; multi-agency working and information sharing; professional curiosity; the role of fathers; harmful social media use and content; and providing early help services to families.

Recommendations to the partners involved include: take a whole-family approach when children are not attending school for health reasons; ensure a lack of engagement in team around the family meetings is highlighted and escalated; review, with feedback from families, family non-engagement in early help services; audit social care decision-making in cases where child mental health was a risk factor; ensure high quality referrals and information sharing between agencies; train all general practitioners in suicide risk assessment; ensure clinical risk is considered for all children on assessment waiting lists; identify a lead professional in complex cases; reinforce proactive engagement between healthcare services; ensure safety planning incorporates historical risk factors; and offer appropriate interpreter support to families whose first language is not English.

Other resources [Read practice review](#)

4. Local child safeguarding practice review: Ivy

Death of a 2-year-old girl in April 2024. Ivy's mother contacted emergency services stating that she had 'caused' Ivy's death. She was subsequently convicted of murder. Ivy's parents were separated

and there were concerns around custody disputes, domestic abuse, physical abuse, alienating behaviours, and parental mental health.

Learning themes include: private law proceedings; the impact of domestic abuse on children and on parental mental health; physical chastisement; the voice of the child, including non-verbal children; multi-agency working with families that move across boundaries; and intersectionality in the context of risk assessment and support for domestic abuse victims.

Recommendations include: the partnership to work with partner organisations to ensure that learning around risks to children relating to domestic abuse and the multi-agency response to physical abuse is included in the joint targeted area inspection; the partnership to ensure that the policy 'Children and families moving across local authority boundaries' is updated to give practitioners guidance if they are considering case closure when the family have moved to another borough; CAFCASS to provide training to both partnerships (Hertfordshire and Northamptonshire) to improve practitioner knowledge of private law proceedings; both partnerships to promote the use of a framework to assess the impact of a family's intersecting needs; both partnerships to ensure that language used to describe physical abuse, domestic abuse and sexual violence is commensurate with language in statutory guidance; and CAFCASS and ADCS to review policy on who takes responsibility for reporting to court under s7 of the Children Act 1989, in circumstances where statutory involvement occurs during private proceedings.

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

5. Local Child Safeguarding Practice Review 'Eli and Micah'. A benchmarking and impact review of non-accidental injury in young children

Concerns two children, from different families, who suffered brain injuries whilst in the care of parents. Eli died in 2022 from their injuries and Micah suffered significant harm. Benchmarks the cases of Eli and Micah against the Kent thematic review of 'Harm to under 2's' (2022) with suggestions of group exercises and professional responses to learning themes.

General learning themes include: safe sleep advice; domestic abuse; parental adverse childhood experiences; family known to integrated children's services (ICS); maternal mental health concerns; missed opportunities for referral; and impact of cannabis.

Learning themes specific to Eli and Micah include: role of the wider family; young parents; paternal mental health; sibling subject to a special guardianship order; cross-border communication; and support from the third sector.

Recommendations include: organisational safeguarding leads to review how observing safe sleep environments with families can be routinely incorporated into practice; partners to remind staff that information requested as part of assessment of risk and need by ICS is provided when requested and is proportionate to the context of concerns; the ICS should ensure information requests contain accurate family details, and there is recorded evidence of follow up/escalation when information is not received; the partnership to support work towards developing a substance misuse strategy, with a focus on cannabis use; the partnership to commission a video for professionals in relation to parental mental health and children not being considered protective factors; the ICS to consider including in its audit schedule a review of information sharing at the point of case closures; Croydon's front door service to consider dip-sampling information provided

to other local authority areas for the purposes of assessment and enquiry; and partners to consider ways to improve engagement with third sector organisations.

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

Related [Harm to Under 2s in Kent](#). [Case review]

6. Child Safeguarding Practice Review Executive Summary. A review examining agency contact with Alice and family as a route to exploring opportunities to strengthen the multiagency response to child neglect in Oxfordshire

Death of a 10-year-old girl in July 2024. Investigations into the cause of Alice's death were ongoing at the time of this report's writing. Alice and her family became known to local services in July 2020 due to concerns including neglect, school attendance, missed health appointments, and parental mental ill-health. Alice and her siblings were subject to children in need plans on two occasions between July 2020 and August 2022. By November 2023, all four children were subject to child protection plans. Alice and her older sibling had also previously been subject to child protection plans in a neighbouring local authority due to concerns about parental substance misuse.

Learning themes include: the significance of medical and educational neglect; the role of professional reflective practice in cases involving neglect; the use of assessment tools to understand parenting capacity and parental motivation to change; understanding the standard of care across a sibling group; siblings with caring responsibilities; and professional difference and escalation.

Recommendations to the partnership include: review and refresh the local neglect strategy; create a suite of multiagency assessment tools; review and refresh the thresholds of needs document, ensuring a clear focus on neurodiverse children, intersectionality, and sibling groups; improve the accessibility of and promote practitioner confidence in the escalation and professional disagreements policy; include a named role in all multi-agency plans for the escalation of issues including incomplete actions; provide multi-agency reflective group supervision to professionals working with neglect; and develop a schedule of scrutiny for the revised neglect strategy.

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

7. Local child safeguarding practice review: Daniel, summary of learning

Death of a 3-month-old boy in early 2023. Pathology investigations into Daniel's death were ongoing at the time of this report's publication. Daniel's mother was known to have a history of alcohol and substance misuse, poor mental health, and domestic abuse victimisation and perpetration. Daniel's older sibling had been removed from their mother's care and was diagnosed with foetal alcohol syndrome aged 4-years-old. Daniel was made subject to a child in need plan following a domestic incident in February 2023 during which his mother was intoxicated.

Learning themes include: professional curiosity around potential injuries, including rashes; children's social care responses to notifications from police of vulnerable persons assessments; the management of child in need meetings; recording and sharing family history; engagement with fathers; safe sleeping; and information sharing with and from probation services.

Recommendations to the partnership include: embed in practice processes for midwives when parents do not attend appointments; ensure robust information sharing between health visitors,

general practitioners and midwives; ensure shared multi-agency understanding about the processes and requirements for child protection medical assessments; ensure same-day home visits if parents do not attend a child protection conference or child in need meeting; audit multi-agency involvement in children in need meetings; review and share good practice around genograms; explore opportunities to strengthen practice around GP records, particularly for parents where a child has previously been removed; develop a plan to better engage fathers; and review safer sleeping risk assessments and safety planning.

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

8. Concise Child Practice Review Report: WG S71 2023. Child A

Sexual abuse of a child in 2023 by private foster carers. Child A and her siblings had been known to Social Services since 2011, with several referrals from school and police over the years. In January 2023, Child A stated that she no longer wished to live at home and was privately fostered after a private fostering assessment was carried out. Concerns were raised in respect of the relationship between Child A and her foster carer, Child A's mental health and that she was sexually active. In May 2023, a report of sexual abuse was made by Child A against her foster carers.

Learning themes include: home conditions and presentation of children; school attendance; consent and engagement; private fostering guidance and regulations; professional curiosity, evidence based practice, analysing observations and professional challenge; and pre and post COVID-19 and the impact on practice.

Recommendations to the partnership include: seek assurance that practitioners, relevant partners and the wider public have the relevant understanding of what private fostering regulations are; seek assurance that practitioners are confident in assessing suitability and triangulating information through assessment prior to approving a private fostering arrangement, including previous referrals/assessments with other local authorities; all agencies to record that practitioners are documenting valid consent, evidenced as voluntary and informed in line with displayed behaviour; ensure that practitioners record their 'respectful uncertainty' as part of their rationale and defensible decision making; and develop guidance for practitioners for completing assessments for private fostering arrangements, with a parallel plan of reunification or rebuilding relationships with family in place.

Other resources Read practice review online: www.wgsb.wales/31268