NSPCC Repository March 2026

The NSPCC added eight case reviews to the repository in March featuring issues including infant deaths, intrafamilial sexual abuse, children as carers, and abuse in schools

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: Concise practice review re : CPR/072020 Child L

Death of a child from starvation as a result of neglect in June 2020. The police received a call from a friend who was concerned as he had been unable to contact Child L's mother for several days. Police officers attended and found Child L was deceased, whilst his mother was alive but severely dehydrated and malnourished.

Learning includes: multi agency information sharing is crucial in ensuring increased vulnerabilities are identified and responded to; where English is not a first language, it is recognised that additional support and consideration may be required in ensuring full understanding of processes; where there are known continuing health needs, particularly in respect of children, any barriers to engagement need to be recognised and shared with relevant agencies and that these and any mitigating actions are fully documented; and regular meetings and face to face contact are a necessity to ensure vulnerabilities and increased vulnerability are identified and responded to.

Recommendations include: housing providers of shared accommodation should be required to include within standard housing inspections a wellbeing check with a view to helping the early identification of support needs; agencies should take all reasonable steps to ensure that all communication is understood by the service user; safeguarding boards should develop best practice guidelines to support agencies to improve the quality of note taking and recording; allocated health professional to explore barriers to accessing health appointments and support to ensure health needs are met; and face to face contact with individuals and families is vital and cannot be replaced by virtually facilitated visits/meetings.

Other resources Read practice review online: cardiffandvalersb.co.uk/safeguarding-reviews/

2. Local Child Safeguarding Practice Review: Mossbourne Victoria Park Academy

Between February and November 2024, a number of parents expressed concerns regarding their children's experiences at Mossbourne Victoria Park Academy (MVPA). These experiences indicated widespread and long-term abuse of the children.

Learning themes include: harmful practices; cultural problems; and governance shortcomings.

Recommendations include: the Central Federation Board (CFB) should directly engage the Department for Education (DfE) about the appropriateness of 'desking' and whether this sanction, as currently practiced, complies with DfE requirements for pupil dignity and continued education;

design and implement a comprehensive behaviour curriculum for all staff that aligns with DfE expectations, including: comprehensive induction that includes positive behaviour management, child development and trauma impact; leadership training that includes areas such as modelling expectations, non-defensive complaint handling, developing parent partnerships and capturing pupil voice; ensure a qualified behaviour specialist supports pupils in the behaviour support unit as opposed to rotating members of SLT covering this function; the Federation's code of conduct should be revised to explicitly prohibit shouting at individual pupils as a disciplinary measure; the CFB should implement robust mechanisms to support and protect staff who raise concerns regarding the implementation or efficacy of the behaviour policy, ensuring no fear of retribution; the Federation's complaints process should be revised and improved to strengthen its focus on independence, communication and evaluation; review and strengthen the arrangements for internal conduct and disciplinary investigations; strengthen its arrangements for reviewing data concerning allegations and low-level concerns against staff; and the local authority should undertake a randomised audit of a large sample of education, health and care plans (EHCP) to examine: whether Section F provisions are being delivered effectively for pupils, the application of sanctions towards EHCP pupils; whether there have been sufficient reasonable adjustments in the application of the behaviour policy; and pupil and parent satisfaction with EHCP implementation.

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

3. Local Child Safeguarding Practice Review: Andrea

Sexual abuse of a 13-year-old girl in July 2021. Andrea attended A&E with her mother due to abdominal pain and sickness. Tests revealed she was pregnant. Andrea disclosed that she had been raped by her 15-year-old brother. Following the brother's conviction in 2024, a Rapid Review confirmed the threshold for a LCSPR had been met, citing concerns about missed child sexual abuse (CSA) indicators.

Learning themes include: voice of the child and family assessments; victim services; professional curiosity; escalation; collaboration; organisational learning; and leadership and governance. Recommendations to all agencies include: review how CSA is recorded within crime and safeguarding systems to ensure that even where CSA is not the primary category, CSA can still be identified; review current policies, procedures, and training to ensure compliance with the statutory duty to report CSA; widely promote barriers to identifying and reporting CSA and the importance of professional curiosity, and refresh CSA training to reflect these barriers and equip practitioners with the skills to recognise and respond to complex presentations; review and amend initial victim needs assessments and internal auditing tools to ensure staff consistently apply an intersectional approach and the social graces framework; implement a mechanism to consistently capture victim feedback, embedding a child-centred and victim-focused culture; consider developing a multi-agency dataset and CSA analytical framework to enhance understanding of the scale of CSA; and the partnership should seek assurance that nursing practitioners within SEND schools receive targeted training on CSA identification and response. Also suggests there should be discussions at national level on the viability of an integrated IT system across safeguarding partnerships.

Other resources Read practice review (PDF)

4. Local child safeguarding practice review: Lisa

Death of a 17-year-old girl and her mother in 2024. In February 2024, the mother made a 999 call seeking medical support. However, the call was stopped and removed from the system. No ambulance was dispatched. It is understood that Ann died soon afterwards. In May 2024, police officers responded to a welfare check and discovered both Lisa and Ann deceased. Lisa had Down's syndrome, obesity, a heart defect, hearing and visual impairment, and was on a child protection plan under the category of neglect (health and education needs).

Learning themes include: lived experience of the child; the impact of migration; long-term impact of domestic abuse on children and their mothers; and intersectionality.

Recommendations to the partnership include: review its review child protection conference (RCPC) processes; develop and deliver training for practitioners around child protection conferences and step down processes; review expectations around home visits to ensure they are purposeful and proportionate; reinforce the 'Think Family' model when working with children from diverse backgrounds and children with disabilities; provide training on the impact of race, racism, disability, and intersectionality, and how these factors influence families' engagement with services; deliver training on relational and restorative approaches, including the Social GRACE framework; consider how professional language (e.g., 'non-engagement') shapes how services perceive and interact with families; explore the use of the Culturagram model when working with families from diverse backgrounds; ensure that housing services are invited to RCPCs; ensure that learning informs the ongoing development of the local neglect strategy and toolkit; and strengthen and evaluate the use and effectiveness of the partnership's escalation policy. Also includes an appendix on actions taken since the rapid review.

Other resources Read practice review (PDF)

5. Executive Summary of Joint Family Reviews: Local Child Safeguarding Practice Review and Safeguarding Adults Review: Family A and Family B

Explores the experiences of two families, Family A and Family B. Both reviews were prompted by the deaths of the mothers, under complex circumstances and where adolescent daughters were the long term carers for their mother and siblings.

Learning is embedded in the recommendations.

Recommendations include: the use of a multi-disciplinary team approach and where appropriate, multi-agency chronologies would have assisted agencies in understanding the family dynamics and any relevant information, for example parental trauma and health diagnosis, which could have informed plans and decision making; the daily lived experience of the children in both families was not understood or explored by professionals; it is vital to explore the voice of non-verbal children and their daily lived experience within their home; agencies must establish the daily lived experiences of all children within families with complex child/adult needs particularly when children have caring roles; agencies did not explore any historical trauma that the mothers had experienced, and how it had a significant impact upon their mental health and wellbeing; self-neglect was an issue for both women, and this would have added to their complex feelings about asking for and accepting help; agencies identified or were alerted to concerns in respect of both

families yet there was a lack of recognition that this information should be shared; agencies did not explore why the families did not respond to communications and the term "non-engagement" was generally used; there was a failure to respond to the daughters needs as carers and particularly how this impacted upon their mental health and education; there is no evidence that a single agency or collectively, agencies fully understood Michelle and Samantha's capacity to parent and the extent and complexity of challenges that impacted upon this; the links between self-neglect and neglect of children is well established and was not assessed or explored in either review; and there were occasions when the families were signposted or referred to supporting agencies with an expectation that the family, including the children, should take personal responsibility and a presumption that the family had progressed the referral.

Other resources Read executive summary (PDF)

Related
A joint family review (LSCPR and SAR): Family A. [Case review]
A joint family review (LSCPR and SAR): Family B. [Case review]

6. Solihull: Baby Nina

Significant harm to a 5-week-old baby in March 2023. Baby Nina lived with her mother at her grandmother's home and was admitted to hospital cold and struggling to breathe after being found in her mother's flat. Nina was the subject of a child protection plan and a safety plan specified that Nina should not be taken to this flat. Nina's mother had a history of exploitation and trauma and both she and the grandmother were prescribed anxiety/depression medication. A police investigation concluded that Nina's mother would not face prosecution.

Learning points address: adverse childhood experiences (ACEs) and trauma informed approaches; family members as part of safety plans; pre-birth procedures; mental health and parenting capacity; multi-agency supervision; and lead professionals.

Recommendations include: the children and adult safeguarding boards should consider agreeing a strategic approach to practice that includes ACEs and a trauma-informed approach; where complex cases demand challenging decision-making the main partners approve the use of group multi-agency supervision/reflection sessions to be overseen by senior managers; pre-birth procedures to be reinforced across the partnership with specific advice in relation to consent where vulnerable women become pregnant; in complex cases involving many agencies the partnership should consider the appointment of a lead professional who will provide a main point of contact for the family; where family members or friends are key contributors to a safety plan, enquiries, restrictions and support commensurate to those required for the approval of a foster carer should be considered; and ensure within assessments that the mental health needs and subsequent medication a parent/carer is prescribed is considered proportionately to account for potential impact on parenting/caring capacity.

Other resources Read the practice review (PDF)
Read the learning brief (PDF)

7. Local child safeguarding practice review: Child Emma

Disclosure of sexual abuse by a 9-year-old girl in September 2021 regarding her father. At the time of the report, Emma was a looked after child placed with a family member. In 2015, Emma's father was reported to have sexually assaulted Emma's older sister and friend. Emma also reported sexual abuse from her sibling and another family member, who were children at the time. Emma had been subject to child protection planning, and concerns included chronic neglect, poor home conditions, lack of parental boundaries, substance misuse, domestic violence, and Emma's age-inappropriate sexualised behaviour.

Learning points consider: risk to children from an individual of concern if there is no conviction for child sexual abuse (CSA); professional curiosity about a child's behaviour and robust consideration of other CSA indicators; safeguarding procedures when information is shared that a person of concern is having contact with children; and assessment and planning considering all children and adults in the family.

Recommendations to the partnership include: seek assurance about the impact of the CSA training offer on safeguarding practice, which should evidence that all practitioners understand the signs and indicators of CSA and the lived experience of children; seek assurance that assessment and plans relating to CSA effectively recognise and mitigate risk and children are provided with timely support and appropriately safeguarded; undertake a multiagency audit of current practice in relation to CSA (including the quality of reflective supervision given to practitioners) to ensure that learning identified in this review has been addressed; and consider the six partnership recommendations in "I wanted them all to notice" (2024), and develop a multiagency action plan in line with these recommendations.

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

8. Protecting all vulnerable babies better: National Review into the broader safeguarding issues raised by the death of Victoria Marten

National review regarding safeguarding vulnerable babies, prompted by the death of a newborn girl in 2023. Victoria Marten's parents were convicted of various offences related to their daughter's death. Victoria's four siblings, born 2017-2021, had previously been removed from parental care.

Learning themes include: persistent non-engagement; concealed pregnancies; domestic abuse; cross-border movement; escalating risk; limited assessment opportunities; and multi-agency responses to serious offenders.

National recommendations include: include a definition of trauma and a section on safeguarding infants in Working Together to Safeguard Children; require safeguarding partners to work with adult services on parental engagement strategies; update multi-agency public protection arrangements (MAPPA) guidance to highlight and clarify agencies' child safeguarding responsibilities; require all registered sex offenders to notify police of new partners and if they or their partner is to give birth; and ensure that there are robust, formal processes for when a child in need or with a child protection plan moves between local authorities. Recommendations to local safeguarding partners include: ensure robust pre-birth protocols which include concealed pregnancy; take a 'Think Family' approach to supporting parents whose children have been removed; facilitate multi-agency reflection on work with complex and non-engaging families; consider intersectionality when ensuring local services are accessible; develop a shared

understanding of trauma and trauma-informed practice; ensure oversight of all risks in relation to offenders and child protection; develop practitioner understanding of domestic abuse; and ensure case information is consistently updated, includes input from all relevant services, and is ready to be shared with other local authorities. **Other resources** Read national review (PDF) **Related** Summary of the Child Safeguarding Practice Review Panel's national review into the death of baby Victoria Marten. [Online report]