NSPCC Repository November 2025

The NSPCC added eight case reviews to the repository in November featuring issues including child neglect, autism, suicide and children missing education

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: Child Eli

Death of an 18-year-old in February 2023 following an incident on the M1 motorway. Eli reported a significant history of childhood trauma, neglect, violence, and abuse and had multiple and complex mental and physical health diagnoses.

Learning themes include: understanding of childhood trauma; engagement with family members; agency responses to reporting and disclosures; clarifying the legal status of children under relevant legislation; mental health support for young people and transitions to adult services; and commissioning placements and risk assessments.

Recommendations to the Safeguarding Partners include: include trauma awareness in all commissioned safeguarding training; review the effectiveness and timeliness of Family Group Conferencing; review the effectiveness of the existing escalation, challenge and conflict resolution process and reinforce its use across the safeguarding system, including schools; review the multi-agency responses to children's disclosures of non-recent sexual abuse; seek assurance that cultural competence, equality, diversity, and inclusion is embedded into the training offer and ensure that gaps in practitioner knowledge are identified and addressed; ensure that practitioners have a working understanding of the Mental Capacity Act and the Mental Health Act, including clarification of case responsibility and accountability when young people aged 16-18 are placed in CAMHS inpatient hospitals; CAMHS and NHS Hospital Trusts should outline the sequencing of treatments and therapy for children and young people to the wider professional network; 18-25 transitions social workers should have access to the Children's Social Care IT case record system and ensure that this information is appropriately shared with adult inpatient hospitals. Also makes recommendations specific to Oxford Health NHS Foundation Trust on transition arrangements.

Other resources Read practice review (PDF)

2. Child Safeguarding Practice Review: Joanne

Death of a 2-year-old child in November 2023 from a traumatic head injury whilst in the care of their mother and mother's partner. Police are investigating the injury as non-accidental. Joanne had significant complex physical and medical needs from birth and was part of a blended family. Joanne's father and her mother's current partner had a history of domestically abusive relationships or alleged abuse.

Learning themes include: professional curiosity; voice of the child and their lived experience; understanding of the family dynamics and relationships; language and recording in agency records; frameworks for assessing need; and working across local authority boundaries.

Recommendations include: the partnership board should promote resources and training about assessing men in households, and urge the use of genograms, ecomaps and other assessment tools; the partnership should promote awareness of the professional curiosity guidance and support frontline practitioners and managers to improve their critical thinking skills in day-to-day working; the partnership to promote the safeguarding children and resolving professional differences (escalation) policy to all agencies; the partnership to review and strengthen the collective approach to responding to children who have disabilities, in respect of workforce assessment skills, eligibility for access to services criteria, legal frameworks, and understanding the day-to-day experiences of children who have disabilities; and Cafcass should ensure that safeguarding interviews with parties should ideally be undertaken by the same family court adviser.

Other resources Read practice review (PDF)

3. Concise Child Practice Review: CPR 05/2018

Removal of two siblings from the care of their aunt, with whom they resided whilst subject to a special guardianship order. Child A and B were placed with their aunt due to concerns regarding inconsistent, neglectful and abusive parenting. Numerous referrals were made to children's services whilst Child A and B lived with their aunt, relating to concerns including the aunt's treatment of the children, her ability to provide appropriate care, and her allowing the children's mother to have contact and live with them. Both children had an educational statement and neither attended any education provision after primary school.

Learning themes include: safeguarding is everyone's responsibility; home schooling; the impact of cultural differences and professionals' responses; the impact of early childhood trauma; and special guardianship arrangements.

Recommendations to the Partnership include: review and audit staff safeguarding training; support practitioners in environments where there may be barriers to reporting concerns; encourage the use of community leaders and connectors to support reporting; explore arrangements and challenges for working with families; review elective home education (EHE) guidance and practice to ensure it covers how safeguarding concerns are reported and escalated for home educated children; ensure rigorous EHE processes and procedures which include opportunities to review and monitor arrangements; adopt trauma-informed approaches; ensure the lived experiences of children are recorded and understood by professionals; record the rationale for decisions made regarding safeguarding children subject to special guardianship orders; and ensure that special guardianship monitoring and review arrangements are in place and adhered to.

Other resources Read practice review online: cardiffandvalersb.co.uk/wp-content/uploads/2025/04/CVSB-CPR-05-2018-final-report.pdf

4. Local child safeguarding practice review: Zara

Death of a 15-year-old girl in April 2024. Zara was known to several agencies and had diagnoses of autistic spectrum disorder (ASD), dyslexia and hypothyroidism. Concerns escalated in the two years prior to her death with reports of suicidal ideation, harmful online activity, bringing a knife to school, and reports of emotional and physical abuse relating to her parents.

Learning themes include: multiagency working methods and the lead professional role; collective professional challenge, joint management of risk and professional curiosity; understanding specific risk indicators relating to ASD; the voice and daily lived experience of the child; and compassionate understanding of family dynamics.

Recommendations to the partnership include: to improve multiagency working, ensure the practice model 'Families first for children' is understood by all frontline practitioners and that arrangements are clear for a child who has multiple complex needs; design multiagency training on the lead professional role; enhance practitioners' knowledge of the unique nature of ASD, to be alert to specific risks such as online exploitation and emotional and mental wellbeing; look to develop an integrated neurodevelopmental toolkit to aid practitioners and explore the role of ASD advocates; consider the extent to which a child's unique needs influence decisions about the allocation of professionals working with them; and develop a toolkit to encourage non-judgemental and collaborative approaches which are designed to meet the needs of autistic people and work in supportive ways with them and their families.

Other resources Read practice review (PDF)

5. Child Safeguarding Practice Review: Child Yvonne

Death of an 8-year-old girl in September 2024. Yvonne was killed by her mother, who then killed herself. Yvonne had been well known to services since her birth due to complex physical and learning disabilities resulting from a rare genetic condition. Yvonne's mother was known to have a history of mental ill health including low mood, feelings of loneliness, and self-harm and suicide ideation. Yvonne was made subject to a child in need plan in late 2023. In January 2024, Yvonne was made subject to a child protection plan under the category of emotional harm.

Learning themes include: understanding the child's voice and lived experience; understanding the lived experience of parents of children with complex needs; assessments of parent-carers; understanding and responding to the mental health risks and needs of parent-carers; collaborative working, including sharing and seeking information, between child and adult services; taking a whole family approach; and understanding the adult mental health pathway.

Recommendations to the Partnership include: ensure that parent-carer assessments are routinely undertaken, include adult and children's services, and include an evaluation of parental psychosocial needs in relation to parenting capacity; recognise parents of children with special educational needs and disabilities as a group at an increased risk for mental health challenges; evaluate and ensure the effectiveness of reflective supervision; evaluate the effectiveness of whole family approaches, including how well core principles are understood and whether multi-agency relationships have been strengthened; and support collaboration between adult and children's services in cases of parental mental health difficulties.

Other resources Read practice review (PDF)

6. Southwark Child Safeguarding Practice Review: Executive Summary Child H

Death of a 16-year-old girl by suicide. Child H was assigned male sex at birth and revealed she identified as female at 12-years-old. Child H first went missing at 15-years-old, and her family became increasingly concerned about exploitative contacts with adult men, and her drinking and drug use. The risks to Child H escalated once she was in care. She had been living in a semi-independent home, but often stayed away, spending time with a 27-year-old man whom she described as her boyfriend but who was considered to be exploiting her.

Learning is embedded in the recommendations.

Recommendations include: develop an overarching adolescent strategy that includes: an updated multi-agency strategy to safeguard adolescents, including children and young people who go missing, review of current systems capacity to ensure that practitioners have the necessary knowledge and skills in working with children and young people at risk of and experiencing exploitation, and update guidance on children who experience extra familial harm; develop a plan to support the mental health needs of young people, particularly those with complex needs or who are vulnerable, during times of transitions so that they are accessing mental health support and services; develop a multi-agency response to safeguarding children and young people online to ensure improved awareness of the risks, supporting assessments which include consideration of online activity; ensure children missing education are effectively responded to and are adequately supported in gaining improved access to education; a multi-agency response to support vulnerable children and young people with children's social care involvement who are awaiting gender identity development services (GIDS), to bridge the gap in service and support whilst awaiting GIDS.

Other resources Read executive summary (PDF)

7. Child Safeguarding Practice Review: Ibrahim and Yusuf

Removal of two adolescent siblings from the care of their mother. In April 2024 the children's father contacted the emergency duty team expressing concerns about the condition of the home, the mother's mental health and the children being left alone. Ibrahim, aged 17-years-old at the time of the incident, has severe autism and is non-verbal. The children's father alleged that he had seen Ibrahim being restrained. Yusuf, aged 15-years-old, spoke about being subjected to physical assault from his mother.

Learning includes: ensure the voice of children is central to understanding their lived experience, including children who are non-verbal; ensure a robust response to neglect, both adolescent and medical by all agencies; the need for a strong system of case coordination and lead professional arrangements to enable early identification of a pattern of missed appointments and understanding of the reasons and an agreed response; and the need to evidence that the needs of young carers are identified and responded to.

Recommendations include: systems change in that assessments of children who are non-verbal demonstrate their voice is heard; commissioners of primary care should assure themselves that within GP practices that children are appropriately coded and the 'reasonable adjustments digital flag' used to ensure any reasonable adjustment for the children and their families are made; seek assurance that the system-wide family support case coordination model results in families being supported to ensure the health needs of children with complex needs are met; assurance that partner agencies' 'was not brought' policies explicitly recognise the vulnerability of children who

are non-verbal and have a learning disability not being taken to appointments and safeguarding and escalation actions are reflected; and assurance that the newly developing approach to young carers can demonstrate impact, with increased numbers of young carers being identified.

Other resources Read practice review (PDF)

8. Child Safeguarding Practice Thematic Review: Summary review families A and B and C

Thematic review exploring three cases of chronic child neglect. The cases of Families A, B and C shared themes including children missing education or medical appointments, poor home conditions, children receiving poor nutrition, children with poor hygiene, and parents or children who have additional learning or physical needs.

Learning themes include: identifying and responding to neglect and emotional harm; child protection planning; responding to allegations of physical and sexual abuse; exploring findings from previous serious case reviews; and considering equality and diversity.

Recommendations to the partnership include: implement a standard multi-agency neglect assessment tool; raise awareness of the role of adult agencies when working with families known to children's services; ensure that all assessments related to parents include clear information regarding their parenting; ensure multi-agency overview of cases that do not achieve consensus at case conferences; ensure parenting assessments are used as benchmarks for measuring progress; ensure legal services provide clear guidance regarding the use of social care assessments in legal proceedings; embed the use of multi-agency chronologies; ensure all concerns about sexual abuse lead to an in-depth pattern analysis of all multi-agency information; include specific reference to the type of domestic abuse, the impact of this abuse, and the support to be provided on all plans relating to children exposed to domestic abuse; further embed the professional escalation policy to foster a robust culture around professional challenge and escalation; and complete a briefing to increase multi-agency awareness regarding working with children and adults where gender identity needs are identified.

Other resources Read thematic review (PDF)