NSPCC Repository January 2026

The NSPCC added eight case reviews to the repository in January featuring issues including intrafamilial child sexual abuse, child neglect, suicide, and infant deaths

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 2025/26/01. Thematic Review: Safeguarding practices in respect of vulnerable babies

Reviews the death of several young babies under 12-weeks-old during and after the Covid-19 pandemic. Commonalties among the families include: involvement with children's social care in relation to older siblings and concerns around neglect and domestic abuse; children being subject to child in need and/or child protection planning; parental substance misuse and/or concerns about the impact of parental mental health; and concerns about home conditions.

Learning themes, incorporated from rapid reviews and two LCSPRs, include: inter-agency working between midwifery and general practice; perinatal mental health and post-natal working; family assessment and the impact of a newborn baby; child protection, child in need and step-down processes; safe sleeping advice; impact of parental mental health and substance misuse on children's safety; working with perceived or actual lack of parental engagement; delivery of universal health services in the context of risk; recognition of the cumulative effect of neglect and poverty on parenting; working with families in relation to their race and cultural needs; and the impact of early help, support, and intervention.

Details improvements already made and makes further recommendations: evaluate the effect of the learning and development sub-group's offer to increase practitioners' understanding of the impact of drug and alcohol use by parents with small babies; the neglect operations group should continue to seek evidence of the impact of GCP2 on professional identification and response to children who may be living with neglect; and the learning from this review, rapid reviews and findings from the independent scrutiny should be disseminated to front-line practitioners and supervisors via a learning lessons briefing note and webinar.

Other resources Read practice review (PDF)

2. Child Safeguarding Practice Review: Thomas

Suicide of a 16-year-old boy in November 2023. Thomas had received a range of statutory and private services since primary school for apparent neurodiversity, and was diagnosed with autism spectrum disorder (ASD) aged 14-years-old. From summer 2023, concerns increased about his mental health and acute levels of distress, despair and suicidality.

Learning themes include: assessing risk of self-harm and suicide in young people with ASD; safety planning; use of emergency departments for the assessment of autistic children and young people in crisis; use of medication and its monitoring; responding to gender distress; online harm and its impact on vulnerable young people; suicide and self-harm prevention; availability of key workers; and coordination of multi-disciplinary services.

Recommendations include: the integrated care board (ICB) and the health and wellbeing board to review how partner agencies train and support practitioners to undertake assessments of self-harm, suicidality and mental capacity, including differences for neurodivergent young people, and to commission practice guidance on risk assessments and safety planning; the ICB and the child and adolescent mental health trust to review the resources available to neurodivergent young people in mental health crisis; the ICB and the mental health trust to review guidance for ensuring progress of patient treatment plans in the event of unexpected absence of key staff; when there is a high risk of self-harm or suicide by a child, there should be an assessment of the parents'/carers' capacity to manage the care of the child, including administering medication, and to offer a carers assessment if deemed beneficial; and the Child Safeguarding Practice Review Panel and the National Child Mortality Database should consider commissioning national learning into the impact of online providers which facilitate suicide or serious harm to children.

Other resources Read practice review (PDF)

3. Local Child Practice Review: Child CE

Presentation of a 5-year-old boy to accident and emergency in June 2023, with a fractured arm. A child protection medical concluded that the fracture should be treated as non-accidental. When examined, CE also had multiple areas of bruising, and there were concerns around his general hygiene and the health of his teeth. CE's mother and partner were arrested, and CE was placed in foster care.

Learning includes: child in need plans need to show clear targets, objectives, outcome measures and timescales; safeguarding partners need to fully understand the reasons behind why a parent may have passive or only occasional compliance with meeting the needs of a child; it is not appropriate to ask a child to provide an account of an injury to another child that they think they may have witnessed; and the financial, emotional and practical care impacts of suddenly becoming the sole carer should be explicit in child and family assessments.

Recommendations include: prioritise the development of a neglect strategy, including an assurance process to monitor completion and quality, from which updates can be provided to the partnership; seek evidence that there is an effective quality assurance process operating around child in need plans; and the partnership may wish to work with the commissioners of the services to see if there is a possibility of there being one continuous record, if this is not possible the situation needs to be outlined to all partners.

Other resources Read practice review (PDF)

4. Local child safeguarding practice review: Child David

Death of a 6-week-old baby in early 2024. David had been sleeping with his parents, and his 9-year-old half-sister in his parents' bed. David's family had many challenges and agencies had been involved with them intermittently over several years, mainly in response to concerns regarding the children's mother's experience of intra-familial physical and sexual abuse.

Learning themes include: information sharing arrangements; specialist assessments, tools and thresholds; professional knowledge and practice; working with families where there are multiple concerns including sexual abuse concerns; leadership and culture; and the wider service context.

Recommendations to the partnership include: ensure the threshold document identifies the 'level of need' by providing indicators for each level, and the service responses that can be expected; ensure the workforce are consistently using neglect assessment tools; review the pre-birth protocol and the pathways for information sharing, multi-agency working and re-birth assessment to drive changes in practice; strengthen knowledge and skills in recognising different types of neglect, the effects of adverse childhood experiences on parenting, working with child sexual abuse risk and families with multiple and complex needs; re-issue the escalation procedure to professionals and agencies; perform a quality assurance audit relating to child in need work to ensure this is being undertaken at the right level, that risk to children is being managed effectively, that there is not an over-reliance on parental self-reporting, and there are SMART plans which promote outcomes for children; and the police should ensure that a family liaison officer is allocated where there has been a sudden unexpected death in childhood.

Other resources Read practice review (PDF)

5. Concise child practice review report: CYSUR 01/2024: Child A

Death of a 7-year-old boy in January 2024. The police received a telephone call from Mrs X reporting that she had caused the death of her son, Child A.

Learning includes: complex safeguarding requires contextual analysis to help determine the likelihood of significant harm; the rights and responsibilities underpinning elective home education (EHE); children who are home educated have a right to be seen and heard; responding to the tension between parental autonomy and the responsibilities of the state; and the context of the local authority receiving the referral regarding Mrs X's mental health.

Recommendations include: promote the rights and wellbeing of electively home educated children and young people, through co-produced resources designed with and for children and their parents; review multi-agency safeguarding training to ensure practitioners and managers understand the contextual experiences of EHE children; review arrangements for submission of domestic incident notifications from the police into children's services; and assess and review the availability of support and training for practitioners receiving and responding to concerns regarding parental mental health.

Other resources Read practice review online: cysur.wales/child-practice-reviews/published-child-practice-reviews/

6. Safeguarding children learning summary into intra familial child sexual abuse

Three cases of intra-familial child sexual abuse within a 12-month period. Considers these children's experiences together and identifies learning that has implications for many services and organisations across the Suffolk safeguarding system. All three children had early experiences of trauma including domestic abuse, parents who used substances, parents who had mental health challenges, neglect and young carer responsibilities. Family dysfunction and the need for statutory agency intervention to support and protect the children was apparent to varying degrees in the children's lives.

Recognises four main learning themes: adultification of children; consideration of the child's lived experience; investigative, responsive and collaborative practice; and risk prioritisation, escalation and decision making.

Details next steps to be taken, such as: training workshops, podcasts, lunch and learn events, 7 minute briefings and other learning to be made available across the safeguarding system; agency/team specific training on the identification, risk recognition, professional challenge and decision making with regards to intra-familial child sexual abuse; and parent/carer and child engagement practice improvement work, to include ensuring services have appropriate access to information about processes and concerns.

Other resources Read learning summary (PDF)

7. Local child safeguarding practice review: Out of Sight; Safeguarding children in elective home education. Children M

Neglect experienced by six siblings over several years. Children M were aged between 4- and 19-years-old when they were removed from their parents' care in March 2024. All six children had been home educated. Three children had been assessed as having autism spectrum disorder, and five experienced significantly delayed communication and language development. Due to concerns regarding missed health appointments, the family were assessed by children services in 2018 and by the speech and language service in 2021. From 2023, reports from police and the housing agency detail concerns including neighbourhood disputes, anti-social behaviour, poor home conditions, and two incidents of a child being left alone in the street wearing only a nappy.

Learning themes include: the risk of children who are home educated becoming unseen by services; home education and children who are not brought to health appointments; information sharing regarding children who are home educated; and taking a whole family approach to assessment and intervention.

Recommendations for the Partnership include: deliver a report on the impact and effectiveness of communication and information sharing arrangements between agencies regarding home educated children; consider increasing the EOTAS (education other than at school) service to offer a health review to all home educated children; increase parents' awareness of parental rights and obligations regarding home education; provide advice to parents on locally available support services and resources for home education; and explore the systems, practice and culture surrounding the barriers to escalating practice and system issues, including use of the professional escalation policy.

Other resources Read practice review (PDF)

8. Child safeguarding practice review: Liam

Death of a 15-year-old boy in April 2024. Liam was known to children's services since birth due to enduring parental issues involving drug dependency, poor mental health, and domestic abuse. Liam lived with his nan under a special guardianship order. Liam had been experiencing increasingly distressful episodes with his emotional wellbeing and mental health.

Learning explores: understanding adolescent worlds to ensure support and protection; relationship-based practice; assessments of need; education provisions for children with a complexity of needs; and responding to increasing risk for children with complex psychological needs.

Recommendations include: children's services should circulate a special guardianship briefing to all agencies involved in the review; the partnership should seek assurance from education services that a multi-agency process has been developed to ensure children missing education have an assessment of their needs in order to support identification and transition into an appropriate education setting; NHS Greater Manchester should develop a range of resources and support to offer children and young people who are awaiting assessment for autism and ADHD; a seven minute guide on working with adolescent boys which explains adultification bias and how to ensure work takes account of gender and identity factors should be added to the partnership website; and the partnership should host a multi-agency learning event on statutory levels of need and risk when working with adolescent children which includes joint protocol responses, escalation processes, working holistically with families in a trauma informed way, and intra and extra familial harms in adolescence.

Other resources Read practice review (PDF)