

NSPCC Repository

April 2026

The NSPCC added eight case reviews to the repository in April featuring issues including head injuries, substance misuse, serious youth violence, and unaccompanied asylum seeking children

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. Serious Case Review: Edward

Admission to hospital of a baby in January 2017. Medical examinations revealed a brain injury, Group B Streptococcus, and bruising. A finding of fact hearing in June 2017 concluded Edward's brain injury was likely caused by the infection, and Edward and his sibling were returned home from foster care. In November 2017, Edward's mother took him to the GP with concerns about a swollen arm. A further finding of fact hearing in 2018 found that Edward's father was responsible for Edward's brain injury which he caused by shaking him. Delay in publishing the review was due to criminal proceedings.

Learning considers: support during pregnancy and response to concerns about parenting; strategy meetings and section 47 investigation; care planning; risk assessment and decision making; legal planning and advice; expert medical evidence in court decisions; planning and support for children returning home; children in need plans; and challenge to practice by the Independent Reviewing Officer (IRO).

Recommendations to the partnership include: ensure that professionals across partner agencies are supported through a model of authoritative practice, to apply professional curiosity, respectful uncertainty, and keep the focus on the child's daily life; ensure that professionals understand the importance of identifying and assessing risk in relation to male partners; ensure that professionals are aware of the factors that would indicate the need for referral for consideration of a pre-birth assessment; ensure that professionals have a shared understanding of the importance of considering medical evidence of potential abuse and neglect within an assessment of the wider context of the child and family; develop guidance and a multi-agency protocol for parental contact when children are in hospital; seek assurance about the effectiveness of arrangements for safeguarding and promoting the welfare of children returning home from care; and review the effectiveness of the IRO 'robust challenge' process.

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

2. Child Safeguarding Practice Review: Child Y summary of learning

At 15-years-old, Child Y sustained significant, life changing injuries from an incident. They had been known to a range of services due to concerns in relation to witnessing domestic abuse including

concerns of physical abuse, poor parental mental health, neglect, their own emotional and mental health, and self-harming behaviour.

Learning includes: the need for professionals to remain curious regarding how to engage with children and young people; the need for culturally competent practice; the need to explore different approaches to direct work and engagement with the family based on their cultural background using informed practice from research; the need to strengthen the use of chronologies as a direct work tool with children and families as well as an assessment tool; a need to ensure that assessments of children presenting with mental health concerns are providing a holistic picture of the child's lived experience from a trauma-informed perspective; and a need for professional curiosity in relation to risks, vulnerabilities and safety.

Recommendations include: the partnership to consider how it can strengthen practitioner skills that enable the child's voice and experiences to be listened to and responded to; the partnership to set up a task and finish group to support work around improving practice and the use of chronologies and genograms; Children's Social Care to review trigger levels and guidance for children who are subject to repeat child protection plans; and the partnership to strengthen knowledge across agencies in relation to the local escalation pathway.

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

3. Child Safeguarding Practice Review: Jamie

Serious head injury to 20-month-old girl in July 2024. Jamie had been removed from her birth parents due to their alcohol and substance misuse and domestic abuse and was in the care of her adoptive parents at the time of the incident. The subsequent finding of fact hearing and Police investigation concluded that there was insufficient evidence the injury was non-accidental. Full care of Jamie was passed back to her adoptive parents.

Learning around the rigour of statutory processes and the role of supervision however identified significant gaps and opportunities for improvement in the safeguarding of children, particularly those in care.

Makes 30 recommendations grouped into six categories: information sharing; meeting arrangements; statutory reviews; meeting parent's needs; system issues; and professional practice.

These include: upload transition plans to the child's social work record; consider a formal handover procedure for all relevant agencies where a child is moving across boundaries; meeting arrangements should include appropriate chairing and timing, with the right people in the room; adoption matching panel members should consider formal training around unconscious bias; statutory reviews should take place in the child's home unless there are exceptional circumstances, and the child's bedroom should be seen; professionals should hear from both parents and see the family together and there should be some unannounced visits; professionals should conduct in depth conversations with foster carers about how they feel about parenthood; address gaps in guidance for professionals around identifying non-accidental injuries in mobile children under 2; recognise the valuable role that supervision plays in safeguarding; and IROs should ensure that health information is gained from professionals and not parents and chase up missing information.

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

4. Local child safeguarding practice review: Harry: Executive Summary

Serious assault of a 17-year-old boy. Harry was an unaccompanied asylum-seeking child and had been in local authority care since 2022.

Learning themes include: information sharing between agencies; the involvement of services such as general practitioners and police in safeguarding and planning discussions; identifying and mitigating the risk of violence in the community and other cumulative risks and harms; understanding across different agencies of the child's lived experience; contextual safeguarding approaches; equity, equality, diversity and inclusion in the local authority corporate parenting strategy; and policy and practice for supporting unaccompanied asylum-seeking children.

Recommendations to the partnership include: ensure that local authority strategies, guidance and training reflect the diverse needs of unaccompanied children; review local practice in the context of findings from the Child Safeguarding Practice Review Panel's 2025 briefing on race and racism; improve information sharing across agencies for all looked after children, including proactively sharing a child's care status with police and health services; review systems for identifying cared for and unaccompanied children and outlining the service expectations for partners; explore the use of strategy and child protection meetings alongside care planning and review meetings; explore approaches to safeguarding young people from violence within a contextual safeguarding framework, particularly in relation to unaccompanied minors; develop professional understanding of the local scale and implications of serious youth violence; and develop procedures to support the identification and management of serious youth violence.

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

5. Child Safeguarding Practice Review: Emma

Significant health consequences for an adolescent girl following years of sustained alcohol dependency. Emma's parents and other family members are known to have supplied Emma with alcohol, and she became dependent on alcohol from 13-years-old. Emma and her family had been well known to services since at least her early childhood, when she was briefly a looked after child. Throughout Emma's childhood, concerns included alcohol dependence in her immediate family, child neglect, family conflict, and reports of child sexual abuse. Police records show 66 investigations linked to Emma. Reports frequently described Emma as intoxicated and related to concerns including criminal damage, sexual assault, and Emma going missing.

Learning themes include: identifying and responding to neglect, especially involving older children; responding to drug and alcohol dependency; the significance of home environments; child sexual exploitation and abuse; the transition between children's and adults' services; professional challenge and escalation; and adultification.

Recommendations to the Partnership include: establish clear pathways for working with parents and children who misuse substances, ensuring these pathways are trauma-informed and emphasise multi-agency working; clarify multi-agency understanding of sexual exploitation; set clear expectations around the circumstances which must be investigated as sexual exploitation; refer children to adult services as early as possible; explore how endings of trusted relationships are currently facilitated and implement a child-centred model to support children as they transition

to adulthood; and make reflective, trauma-informed multi-agency forums available to practitioners.

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

6. Local Child Safeguarding Practice Review: Child L

Death of a 16-year-old boy in February 2022. At the time of this report's writing, numerous people had been charged with murder and criminal enquiries were ongoing. Child L had been known to services since 2011 due to concerns including domestic abuse and the involvement of Child L's older sibling in criminal activity. Following exclusion from his previous school, Child L joined a school for children with social, emotional, and mental health difficulties in February 2019. The school recorded and made referrals to other agencies regarding concerns including Child L's anxiety, depression, weight loss, insomnia, low school attendance, and cannabis use, as well as the risk of child criminal exploitation. Child L and his mother exhibited a pattern of refusing or not engaging with services.

Learning themes include: recognising and responding to the impact of significant cannabis use and its connections to criminal exploitation; assessing and managing children's needs, including delivering high-quality education health and care plans; and escalation to and threshold criteria for multi-agency safeguarding arrangements.

Recommendations to the partnership include: ensure all protocols and tools for responding to child criminal exploitation are coherent with partnership strategies and fully understood by agencies; emphasise recognition, recording, timely responsiveness, and referral in multi-agency training on exploitation; ensure robust oversight and recording of children's social care consultations with other agencies; foster collaboration between agencies, including schools, regarding exploitation; ensure all agencies understand the function of the complex safeguarding team; and ensure multi-agency oversight and planning which responds to risk and vulnerability for children missing from education.

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

7. Child safeguarding practice review: Case AO: Jasmine

Death of a 17-year-old girl in relation to drug use in November 2024. Jasmine was a looked after child who was known to services from a young age and had a history of neglect and adverse childhood experiences. These included parental drug use, custodial sentences and domestic abuse within the family.

Learning themes include: relationships as the foundation of all interventions; partnership working and collective action; enabling practice that spans agency boundaries; supporting adolescent looked after children's resilience and risk awareness as they mature and explore their independence; consistent child-focused practice and the importance of building trusting relationships; and knowing, understanding and managing agency and risk when working with adolescents using alcohol and drugs.

Recommendations to the Partnership include: conduct a comprehensive mapping pathway of the mental health system, considering the effectiveness of pathways in relation to the aims of the

partnership; use existing mechanisms to strengthen multi-agency communication, reflection and accountability across services provided for adults and children; develop specific resources for working with men when interactions between fathers and staff are seen as confrontational, lacking cooperation and proving ineffective; agencies working with children at risk of exploitation should evidence how they support staff to develop skills to map and work with the extended family network; and review processes to debrief and support staff following an unexpected death of a child or young person.

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

8. Child Safeguarding Practice Review: Child C

Death of a 2-week-old baby boy from non-accidental injuries in March 2024. Child C was subject to a child protection plan under the category of neglect. At the time of his death Child C was still in hospital in the Special Care Baby Unit (SCBU) following his premature birth at 33 weeks. Child C's father was found guilty of murder and sentenced to life imprisonment.

Learning themes include: risk assessment and decision-making; family engagement and mental health; domestic abuse, coercive and controlling behaviour; housing and homelessness; and information sharing.

Recommendations to the Partnership include: review how effectively tools, guidance and training support staff to undertake robust multi-agency pre-birth planning that includes dynamic risk assessment and consideration of contingency planning; find ways to support connectivity between Public Law Outline processes and multi-agency pre-birth planning; consider how to raise awareness around how family group decision-making forums can be more consistently encouraged and how potential barriers such as consent can be overcome; review how effectively training, supervision and guidance supports practitioners to utilise all available tools to support victims of domestic abuse, including risk assessment tools and use of DVDS; consider how to ensure practitioners understand the role of housing departments and where necessary consistently involve Housing in safeguarding children; and build on recent work around information sharing, ensuring that key information is routinely shared and responded to with appropriate professional curiosity to inform assessments, including family background information held by each agency, parenting observations or incident reports when a child is in hospital.

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