

NSPCC Repository

May 2026

The NSPCC added eight case reviews to the repository in May featuring issues including radicalisation, suicide, children as carers, and parents who have a mental health difficulty

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 Learning Review: Anna and David

Unrelated suicide and attempted suicide of two adolescents in late 2023. David then passed away in December 2024. Both Anna and David were care experienced and 18-years-old at the time of their deaths.

Learning themes include: suitability of placement; transition from services for children to services for adults; safety planning; support for neurodivergent and gender diverse young people; and online harms.

Recommendations include: multi-agency partners working with children in care and leaving care should continually review their approaches to safety planning to ensure that they meet the needs of neurodivergent children and young people and that they are using contemporary, current tools and resources akin to what has been detailed within this review, such as autism adapted safety plans (pages 10-12); the partnership should contribute to revisions to the London safeguarding procedures by way of creating a standalone guidance section upon working with children and young people who are transgender, non-binary and gender questioning who may also be neurodivergent; all partners should commit to actions and recommendations identified in the separate and more detailed multi agency audit upon the transitions of children to adult services; the partnership should ensure that the online harms component of the current training programme is contemporary and includes information and awareness of threats to children's welfare such as suicide promotion platforms; and disseminate further government guidance and policy as and when is possible, alongside key developments from the NHS, upon supporting young people and their gender identity through access to regional gender identity clinics.

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

2. Child Safeguarding Practice Review: Child A

Death of a 2-year-old boy in August 2023. The father of Child A was found guilty of his murder. Child A became a child in care through an interim care order and was placed with foster carers before living with the father.

Learning themes explore: how effective parenting assessment processes are; how realistic professionals' expectations are of an individual's ability to parent when they have never had any involvement with a child; whether services have a good enough understanding of the role of the

extended family in safeguarding and protecting children; if child in our care/child in need processes are sufficiently robust and if plans align effectively; and whether there are barriers to a family being honest with services.

Recommendations include: consideration should be given as to whether an “in-home” assessment would be more effective in assessing parents’ ability to cope alone, rather than a residential assessment; plans and assessment frameworks should have built into them consideration as to exactly what the expectations of parents are and whether those expectations are realistic and achievable; the lead agency should ensure that all plans are coordinated and align effectively into a single, comprehensive, master plan; and agencies must have inbuilt into their systems the importance of robust and effective multi-agency working, whilst maintaining constant professional curiosity.

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

3. Local Child Safeguarding Practice Review: Baby Aspen

Physical abuse and neglect of a baby. Videos were discovered and shared with the police depicting assault, neglect and distressing interactions involving Baby Aspen's mother and her partner. Baby Aspen's mother was in care as a child and experienced trauma and adverse childhood experiences. Baby Aspen was initially on a child in need plan, which ended at 4-months-old. There were ongoing concerns around parental mental health, domestic abuse, and housing instability.

Learning themes include: responding to complexity; power dynamics, language and impression management; parental mental health, survival mechanisms and indicators of harm; support networks and risky men; information loss and triangulation; weight given to and triangulation of referrals; and assumptions about professional remits and capacity.

Recommendations include: consider co-producing a corporate grandparent framework to ensure nurturing long-term support for care leaver parents and their children; partner agencies to explore developing an integrated chronology that documents historical and contextual information, significant events, and referrals and is accessible to safeguarding partners; agencies to review and clarify the roles of personal advisers in supporting care leavers who are parents; agencies to explore ways of improving timely access to early interventions that support the wellbeing and mental health of children in care; agencies to strengthen the assessment and consideration of parental mental health, by exploring the involvement of qualified mental health professionals in relevant safeguarding assessments and encouraging training for frontline safeguarding staff; and the partnership to assess the impact of the current approaches to disseminating learning and workforce development in terms of achieving change in multi-agency practice and improving outcomes for babies and children.

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

4. Child safeguarding practice review: Learning from consideration of Child E and her family

Death of a 14-year-old girl from suspected suicide. Child E lived with her mother and siblings following her parents' separation. Child E experienced mental health problems, including self-harming behaviour, and took a paracetamol overdose in 2022. Child E had also made two reports of sexual abuse against her father, of which the police decided to take no further action.

Learning considers: response to a child's mental health; response to parental mental health; hearing the child's voice; reports of child sexual abuse (CSA) within the context of an acrimonious separation; children in private law proceedings; the specific needs of electively home educated children; and working with middle class, professional families.

Recommendations include: professionals to be briefed about the local CSA pathway in order to clarify responsibilities if an allegation is made to them, and to enable professional challenge if the pathway is not followed; ensure that agencies understand the requirement to have a strategy meeting and a review strategy meeting after parts of a CSA investigation are completed; the partnership to share a statement outlining the expectation that professionals are aware of the need to challenge themselves and each other when there is a reliance on private law but a concern that a child may be suffering significant harm; the partnership to voice its commitment to ensuring that emotional harm is responded to in a timely and decisive way, asking agencies to ensure that staff are trained to work with all types of families where there is extreme parental acrimony; and the partnership to write to the Child Safeguarding Practice Review Panel and the Department of Health advocating the need for guidance on governance and clinical responsibility for risk management and shared care between NHS mental health providers and private providers delivering mental health interventions to children.

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

5. Local Child Safeguarding Practice Review: Safeguarding infants (Baby A and Baby B)

Review triggered by two separate incidents where babies suffered harm in a context of parental mental health difficulties. Whilst the specific circumstances vary and can be found in the full reviews linked to this one, there are shared themes in respect of working with affluent parents, risk assessment, the complexity of cross border working and the effectiveness of safeguarding processes. Both families were White British, and of affluent socio-economic background with parents accessing private and public healthcare services. Prior to both pregnancies, there had been no history of contact with safeguarding services, nor awareness of the presence of mental health difficulties or substance misuse for parents as adults.

Learning includes: the need for clear and robust multi-agency pre-birth protocols, particularly for cases of late engagement, concealed pregnancy, or where mental health or domestic abuse are factors; improving joint working between adult and children's services when parental mental health difficulties are a factor; strengthening guidance on realistic safety planning and multi-agency accountability; improving cross-border communication protocols and integration of private provider information into safeguarding processes; strengthening pathways to assess fathers' capacity and risk, particularly where they present with mental health issues or a history of controlling behaviour; guarding against assumptions that affluence equates to safety or resilience; and the importance of formally recognising the presence of domestic abuse in shaping risk to unborn and newborn children.

Recommendations focus on: strengthening knowledge and skills; improving processes and pathways; and enhancing communication and accountability.

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

Related

[Local child safeguarding practice review: Baby A.](#) [Case review]

[Local child safeguarding practice review: Baby B.](#) [Case review]

6. The Southport Inquiry phase 1 report: Volume 1 and Volume 2

Phase 1 report of the inquiry into the circumstances surrounding the attack by 17-year-old Axel Rudakubana (AR) at a children's dance club in Southport in July 2024. Aims to establish a definitive account of the events leading up to the attack and the attack itself, and to review the decision making and information sharing by agencies that had contact with AR prior to the attack. Split into two volumes, Volume 1 focuses on the events and consequences of the attack and Volume 2 examines the roles and actions of the agencies involved.

Fundamental problems identified include: the failure of any organisation or multi-agency arrangement to take ownership of the risk; poor information management and information sharing between and within agencies; excusing harmful behaviour on account of the presence of autism; limited oversight and intervention around online behaviour; and the role of parenting.

Phase 2, to be published in 2027, is expected to assess the adequacy of multi-agency systems to address the public safety risk posed by young people who display a desire to commit acts of extreme violence.

Recommendations to inform Phase 2 include: consider what single agency or structure should be appointed to record, monitor and co-ordinate interventions for young people who present a high risk of serious harm; consider the development of a shared multi-agency risk-assessment tool that is clear, accessible and suitable for use across services; and consider whether there should be a further ability to restrict or monitor access to the internet on the part of young people, if a significant threshold is passed concerning the risk they pose to others.

Volume 2 contains 64 further recommendations relating to: the attack; weapons and poisons; online harms; policing; Prevent and counter terrorism policing; social care; AR's healthcare; education; and AR's family.

Other resources [Read the report \(PDF\)](#)

Related [Summary of the Southport Inquiry: phase 1 report.](#) [Online report]

7. Child safeguarding practice review: Molly

Death of a 14-year-old girl in 2024 after ingesting medication at home. Molly had been registered as a young carer from 9-years-old and was home educated at the time of her death. It was later discovered that Molly had been displaying behaviours associated with an eating disorder and had previously taken an intentional overdose of medication. Prior to her death, Molly was known to have had suicidal thoughts and self-harmed.

Learning themes include: the need for a greater focus on young carers and young carers in transition; and the need for better information sharing across all services about young carers, the person they care for and their families.

Recommendations to the Department for Education (DfE) include: include an expectation in "Working together to safeguard children" that local authorities and integrated care boards should

adopt “No wrong doors for young carers”; include 'young carer' as a characteristic in local registers of children not in school; and propose that “Working together to improve school attendance” guidance is amended to include young carers in the attendance data analysis and in the 'groups of children to be particularly mindful of' section.

Recommendations to NHS England include: review guidance on coding or flagging of young carers to promote a whole family approach; review guidance on structured medication to include consideration of the impact of long-term use of medication on dependants and young carers; and consider the gap in specialist psychological support for people with diabetes who have fears of weight gain from insulin and the potential impact on diabetes management.

Also includes some local recommendations.

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

8. Child Practice Review: Concise Child Practice Review: NWSCB 2023/1

Death of a 14-month-old girl in December 2022, who was found unresponsive in her cot. A postmortem concluded cause of death was Invasive Group A Streptococcus infection. The child lived with her parents and older brother and there were concerns around housing issues, substance misuse, domestic violence, disputes with neighbours, the child's weight, the cleanliness of the children and home, and missed health appointments.

Learning considers: safeguarding reports and response, and the threshold of significant harm; feedback from safeguarding reports; parental engagement with early preventative services; and escalation of concerns.

Recommendations for improvement to general safeguarding management and co-working arrangements include: review the 'Was not brought' standard operational procedure following publication of the All-Wales NHS 'Was not brought' guidance; and promote the use of the AWARE mnemonic (used to gather information about children) within response police officers and ensure this is reflected within the quality of CID16s. Recommendations to the local authority include: arrange multiagency sessions to raise awareness regarding the safeguarding thresholds and to promote better understanding around each agencies' professional language and terms; raise awareness of the process of escalating safeguarding concerns; and review their processes to relay the outcome of safeguarding reports to agencies that have made reports.

Other resources Read practice review online: www.northwalessafeguardingboard.wales/practice-reviews/