NSPCC Repository June 2026

The NSPCC added eight case reviews to the repository in June featuring issues including racism, child neglect, child mental health, and home 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 / Domestic Homicide Review: Family D (Clare and Adam) Learning briefing

Homicide of a 47-year-old mother (Clare) by her 17-year-old son (Adam) in 2023. Adam and his family were known to multiple agencies over a 13-year period. Adam was diagnosed with autism at an early age and was exposed to domestic abuse. He experienced multiple placement moves and mental health issues, with professionals struggling to meet his complex needs.

Learning points address: early help and early identification; lifelong neurodivergent needs; children experiencing domestic abuse; trauma-informed practice; complex multi-agency involvement; parental advocacy; fixed narratives and unconscious bias; understanding of care, education, treatment and review (CETR), local area emergency protocol (LAEP) and the dynamic support register (DSR); multi-agency risk assessment: diagnostic overshadowing in health settings; child-to-parent abuse; transferring safeguarding information between settings; transitions from residential homes; a 'champion' for children with fractured family relationships; and legal frameworks for older children.

Recommendations include: local partnerships must ensure practitioners are trained and supported to recognise and respond to child-to-parent abuse, and address gaps in skills, guidance, or supervision; the partnership should obtain assurance that CETR/LAEP processes for under-18s are being used properly, covering attendance, information sharing, holistic risk assessments, contingency planning, challenge/escalation, and decision-making; a working group should review neurodivergent care pathways, ensuring staff understand how to navigate them and that information sharing is timely and focused on child safety; commissioners should explore integrating pathways for children with complex neurodivergent needs, mental health issues, and challenging behaviours; and the partnership should conduct a multi-agency audit of children with the highest levels of concern.

Other resources View learning briefing (PDF)

2. Child Safeguarding Practice Review: Child LA

Admission to hospital of a child presenting with serious health and development concerns, including malnourishment. Child LA was a non-verbal autistic child who was electively home educated. They received services from a range of different health providers, including many non-

NHS and some recorded outside the UK. Child LA lived at home with their parents, sibling, and grandmother.

Learning considers: the hidden harm and invisibility of the child; the voice and needs of a non-verbal autistic child; the impact of COVID-19 on the offer of services for hard to reach families; elective home education (EHE), educational provision and educational progress; use of private and alternative medical providers driven by parental choice and beliefs; medical neglect and/or fabricated or induced illness (FII); how working with families who are more affluent impacts upon professional curiosity; and the role and involvement of fathers and grandparents.

Recommendations include: the partnership to work with local statutory and voluntary organisations, who support parents, to raise awareness of the importance of the evidence base of interventions accessed for children who experience autism; partners to consider the development of a multiagency pathway for information sharing and oversight to ensure EHE children are known, their needs are understood and to promote safeguarding oversight; and the partnership to assure themselves of the effectiveness of their local systems relating to the safeguarding practice for children electively home educated.

Other resources Read practice review (PDF)

3. The Independent Report: Child River

Significant harm suffered by a 17-year-old boy following him spending six days in seclusion in an accident and emergency department of hospital. River had been discharged from a tier 4 mental health unit three days earlier and had had multiple admissions to hospital over the previous year. River has been diagnosed with psychosis, ADHD, possible ASD, as well as having undiagnosed complex mental health conditions.

Learning themes include: the voice of the child; professional disagreement; responsibility, accountability and ownership of care plans; thresholds for the provision of tier 4 mental health care units for children; discharge arrangements in complex scenarios; intersectionality; and racism.

Recommendations to the partnership are embedded in the learning and include: disseminate learning through joint structured meetings, joint training sessions, or updated joint protocols between the respective agencies; develop a policy on managing high risk cases and mismatched expectations of respective agencies; advocate for the implementation of anti-racist practice standards for working with children and families and staff; ensure that operational staff involved in highly complex, challenging case work are given dedicated time to work together and develop effective professional relationships, and have 'think space' to allow for reflection on the impact of the work on individuals; the revised escalation and resolution policy should be communicated across the safeguarding system; provide training and development opportunities in cultural humility, conscious/unconscious bias and intersectionality; and children's social care and child and adolescent mental health teams should come together formally once every six months to discuss capacity, challenges and opportunities.

Other resources Read practice review

4. Child safeguarding practice review: Robin

Suicide of a 14-year-old child. Robin had previously attempted suicide earlier in the same year while in their mother's care. A safeguarding referral was not made by the hospital at the time, and Robin was not reviewed by mental health services at the hospital. Robin's father took Robin to the GP the following day, and a referral was made to the emotional wellbeing hub. Robin was assessed a few months later and placed on a waiting list for counselling, where they remained at the time of their death.

Learning themes include: waiting times for mental health assessment and support; referral and assessment processes; impact of maternal mental health; and information sharing and communication.

Recommendations to Partnership agencies include: ensure timely and face-to-face mental health assessments; consider the need to reduce waiting times for mental health services and ensure appropriate safety plans or other avenues for support are in place while young people wait; improvement of the quality and quantity of inappropriate case referrals to early help and safeguarding (MASH) processes across agencies, through provision of training and supervision and guidance resources; emphasise the importance of a Think Family approach to ensure holistic assessments and support packages for families; support practitioners to utilise tools for accurate recording of the family on electronic health records, genograms and ecomaps; support staff to recognise their responsibility to share information effectively when there are safeguarding concerns about a child; and to understand the importance of data protection, confidentiality and consent and that these should not delay or be a barrier to sharing information about child safeguarding concerns.

Other resources Read practice review summary (PDF)

5. Local Child Safeguarding Practice Review: Serin

Suspected suicide of a 16-year-old girl in March 2022. At the time of her death Serin was an in-patient at a local hospital awaiting a tier 4 provision. Previously Serin had several long stay admissions to hospitals associated with mental health difficulties.

Learning themes include: the effectiveness of early interventions; special educational needs and provision of education; consideration of risk and safety planning; effective multi-agency working; and child sexual abuse (CSA) and the support available following disclosure.

Recommendations to the partnership include: review the work undertaken to improve mental health services for young people to measure progress; ensure the need to assess parents as carers when caring for children with additional needs is embedded in practice; develop practice guidance which details clear expectations in relation to how families with children experiencing mental health crises are supported by agencies, including recognising the disruption to family relationships because of long stay hospital admissions, clarity about who the lead professional is, joint working for s117 planning, and, clearly communicating plans to parents; seek assurance that when a child leaves tier 4 provision there is continuity of care and support; review the current CSA pathway and undertake regular audits of practice in this area; and start developmental work in relation to best practice at strategy meetings to support early decision making and planning. Highlights two areas for the attention of the National Panel: the urgent situation regarding the national shortage of beds in tier 4 provision; and the growing pattern of CSPRs being perceived as a critical element in coroners' inquests and the impact of that on families and services.

Other resources Read practice review (PDF)

6. The Barton Family Child Safeguarding Practice Review: Summary report

Serious incident in 2020 involving information that videos were circulating showing serious burns to an infant. Further indications of severe neglect arose from the visit undertaken in response. The Barton family includes seven children aged between 1-17-years-old at the time of the incident. The family have extensive history with services including from when the mother was a child. All the siblings had previously been on child protection plans.

Learning themes include: multiagency response to risk including information sharing, drift, and decision making; the impact of the intersections of race, gender, mental health and socio-economic status; bias and assumption; working with resistance; consent; and response to disclosure.

Recommendations to the partnership include: review escalation policy and processes; develop a strategy and action plan to ensure all agencies are sufficiently skilled and able to understand the lived experiences of children; ensure that the workforce is confident in understanding how racism and bias impact child protection responses to Black children and their families; provide practice guidance for staff working with large sibling groups with complex presenting issues; ensure children are visited in line with procedural expectations; ensure that staff understand when they can dispense with gaining parental consent, and the importance of approaching both parents where there are barriers; seek assurance that guidance on engaging with resistant families is known and used in decision making and planning; review the effectiveness and impact of the neglect strategy and toolkit; police should ensure frontline officers are equipped to recognise and respond to exploitation; and local authority housing should develop a process to facilitate swift moves for families fleeing risk.

Other resources **View summary report**

7. Local Child safeguarding practice review: Mira

Suspected non-accidental injuries to a 4-month-old girl. Mira was the only child to parents of Eastern European origin and there were conflicting reports regarding the amount of time that Mira's parents had been together.

Learning themes include; parental mental health; including fathers in assessments; cultural competence; language support; and domestic abuse.

Recommendations to the partnership include: ensure that interpreting guidance includes trigger points for where an interpreter should always be offered e.g. safeguarding and domestic abuse, and not to use family or friends unless in an emergency; record audits should have a field for evidence of use of interpreter; source training to ensure that the workforce understands the difference that cultural competence makes to working effectively with those from different cultures; create resources to increase cultural knowledge amongst professionals; develop a strapline for use in all training that recognises the need for professionals to be able to listen to parents but also talk to other professionals such as 'Listening to families is important; talking to other professionals is vital'; produce a 7-minute briefing to use in training regarding professional challenge and courageous conversations with families; seek to understand if there is any similar learning locally or work being undertaken by the Domestic Abuse Partnership Board regarding

assurance that victims of domestic abuse do not have expectations on them to be the sole protector of their child/ren; develop a case study regarding Mira's story to use in single and multi-agency training; and children's services should consider reviewing support levels guidance and clarity of referral pathways at levels 2 to 4.

Other resources Read practice review (PDF)

8. Extended Child Practice Review: Child A

Serious injury and self-harm to an 18-year-old in April 2022. The local authority had periodic involvement with Child A and her family throughout her life. Following Child A's disclosure of being a victim of sexual assault in October 2020, her wellbeing began to deteriorate noticeably. At the time of the critical incident, Child A had been a child looked after by the local authority since October 2021. Between October 2021 and April 2022, Child A was placed in unregulated, supported independent accommodation in Northwest England and hotels in North Wales.

Learning themes include: an integrated needs-led approach when there is recurrent presentation of distress and risk of significant harm through suicidal intent; and employee wellbeing, including lone working and post-critical incident support.

Recommendations to partnership agencies include: integrated and locally based care and support provision that provides intensive care and therapeutic support to meet the needs of adolescents with self-injurious and suicidal behaviours; children experiencing recurrent distress and suicidal thoughts and behaviours to receive a multi-agency integrated care and risk support plan that meets their needs 24 hours a day; a review of how risk assessments are completed for employees working with children in receipt of an integrated care and risk support plan; interprofessional training for employees working with adolescents with self-injurious and suicidal behaviours, to build relationships and knowledge of multiagency practices; and improving effective communication with services in England for children with an integrated care and risk support plan.

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