

NSPCC Repository

July 2026

The NSPCC added eight case reviews to the repository in July featuring issues including child sexual abuse, serious youth violence, suicide, and no recourse to public funds

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. Learning review report: Child E: Executive summary

Serious sexual assault of a 12-year-old child in Autumn 2023 by an adult male. The perpetrator had engaged with the family on several occasions before the significant event took place. Child E lived at home with their mother and had received the support of many services throughout their life due to persistent concerns related to parenting capacity, risk of sexual or physical harm from multiple adult males, and neglect.

Learning themes include: applying Getting it right for every child (GIRFEC) principles; the quality and effective use of chronologies; escalation; and the role of housing.

Suggested strategies for improvement include: police should review staff training in child sexual abuse, child sexual exploitation, and harmful sexual behaviour to ensure it equips staff with the skills they need to identify and respond effectively to concerns of sexual harm; police should be routinely involved in multi-agency meetings for high-risk cases; review resources for assessing neglect to ensure staff have the competence and confidence they need to work with families where neglect is present; when planning meetings take place it is important to ensure all those dealing with the presenting risks are fully involved and can contribute to the assessment; multi-agency meetings should include education, pending allocation, and a review of the processes for allocation, perhaps with a flagging system for complex cases, should be considered; strengthen joint protocols for children in need, where a parent/parent and child have a learning disability; and review cases subject to lengthy delays and develop a monitoring system, overseen by managers, to ensure due process is followed when agreement is reached to refer a child for compulsory measures.

Other resources Read review

online: www.edinburgh.gov.uk/downloads/download/14017/edinburgh-child-protection-committee

2. Child Safeguarding Practice Review: Child JJ

Suicide of a 14-year-old boy in September 2023. Child JJ had made a previous suicide attempt in 2022 and was living with his father under a supervision order 10 months before his death, due to a lack of suitable placement. Child JJ was an autistic child with ADHD and a learning disability.

Learning themes include: whole family approach to domestic abuse; trauma informed approach and a therapeutic response; child to parent violence; placement suitability; and supervision orders.

Recommendations to the safeguarding board include: implement a whole family approach to domestic abuse and ensure all practitioners working with children and their families have a sound understanding of its dynamics, including coercive control; clarify the escalation route where practitioners are concerned that lack of transport is increasing risk to a child; continue to embed 'of concern' meetings in practice; work with CAMHS to ensure its services are sufficiently flexible and take account of the child's preferred ways of engaging with the service; where a child with no medical need is placed in a hospital environment because of lack of appropriate accommodation, the multi-agency process for managing this situation needs to be clear and distinguish between strategic planning to meet the day-to-day needs of the child; review the referral process for residential care to ensure that practitioners who know the child and their background complete the information being sent to prospective providers; ensure supervision order guidance is clear, fully understood and embedded into practice; develop a multi-agency framework for responding to child to parent violence; and all staff working with children at risk of harm should have the opportunity for regular reflective supervision.

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

3. Learning review report: Family C

Serious abuse and harm experienced by four siblings over a 16-year period. The children's mother (Adult E) and father/stepfather (Adult F) were convicted in November 2023 of multiple counts of neglect, repeated physical assaults including attempted murder, offences relating to the misuse of drugs, and multiple serious sexual offences, including rape. Six other adults were convicted of sexual and physical abuse.

The children lived with their parents until June 2019 when they were moved to live in a kinship care arrangement. There had been multi-agency involvement with the children since 2007, including their names being on the child protection register for periods of time.

Parts one and two identify learning about the impact of agency involvement with the children when they lived at home. Part three considers the children's experiences during the investigatory and court processes.

Learning themes include: assessment of needs, strengths and risks; how services listen to children and interpret non-verbal behaviours; and communication and collaboration across agencies and authorities.

Suggested strategies for improvement include: the child's voice and experiences should take prominence within recording, assessments, decision-making and planning; professional opinion given as part of assessment and decision-making should always be supported by factual evidence of a child's health, wellbeing and safety; supervisors should demonstrate oversight and accountability and provide critical reflection for the work of staff; staff should be confident in recognising and responding to neglect as harm, including indications of dental neglect; children's rights must be protected and promoted throughout all stages of child protection investigations and court processes; staff should be enabled to apply trauma informed principles within their work;

and staff and managers should have access to early and appropriate psychological supports when working in complex investigations.

Other resources Read review online: www.glasgowchildprotection.org.uk/article/5337/Learning-Reviews-and-Learning-Packs

4. Child safeguarding practice review: Mashal

Death of a 4-year-old child in January 2025 and admission of their twin to hospital. Cause of death appears to be indicative of neglect of their health and care needs. The children's parents moved to the UK from Bangladesh shortly before the twins were born. Care proceedings were initiated soon after their birth and they were the subject of child in need plans until May 2021. After this, they were rarely seen professionals.

Learning themes include: child in need planning following serious safeguarding concerns; working with families who are new to the UK and do not have recourse to public funds; expectations regarding gender roles and relationships in minoritised cultures and religions; parenting twins; response to was not bought (WNB) to health appointments; and escalation of concerns and professional challenge.

Recommendations include: leaders in all organisations to facilitate safe spaces and training of professionals to enable them to discuss race, cultural identity, and bias openly; review local procedures to include the expectation that multiagency meetings/plans always include reflection and challenge on cultural bias; develop a checklist to be used when a child is on a plan and the parents have no recourse to public funds; review local procedures to include the expectation that when a child has been the subject of care proceedings which were not preceded by child protection procedures, that formal consideration is given to whether there is a need for a child protection conference at the end of proceedings; relevant partner agencies to provide assurance on improvements in the use of the WNB policy; and the partnership to ensure that adult mental health services are consistently engaged in multi agency planning when the child/ren of a parent with mental health issues may require safeguarding.

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

5. Child Safeguarding Practice Review: Alex: Executive summary

Serious knife injuries to a 16-year-old boy who was stabbed. Alex is a care experienced child and the subject of a care order.

Learning themes include: review Alex's history and lived experience and examine his vulnerability to child criminal exploitation, including the impact on Alex of the decision to place him out of borough as part of a safety plan; evaluate the effectiveness of risk assessment processes and how his risks and needs were seen from a multi-agency perspective; evaluate the impact on Alex's outcomes given his lack of formal education provision since 2022 and how his education placements out of borough met his learning needs effectively or not; explore the impact that Alex's race, ethnicity and culture had on service responses to him and his family, including how agencies assess, evaluate and understand family's spiritual and religious beliefs; and understand the impact

on Alex of his wider family context and in particular his relationship with his family's 'home country' and how agencies assess the impact of those relationships.

Recommendations include: safeguarding partners will seek assurance as to the effectiveness of positive statutory and independent advocacy for children and young people who are subject to a child protection or child in need planning or subject to Pre-MACE discussions to ensure their voice is heard in risk management and care planning; all safeguarding partners to fully understand the impact and outcomes associated with the National Referral Mechanism (NRM) process; and the safeguarding partners will develop a protocol and operational policy for when decisions are made to move children and young people out of borough.

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

6. Thematic review of knife crime and serious youth violence: Sheffield

Examines the lived experience of four adolescent boys aged 15-17-years-old who were impacted by three separate incidents of knife crime and serious youth violence (SYV) during 2025. One of the cases involved Child X, who was murdered in February 2025 by a fellow pupil (Child Y) at the school they both attended. Familial dysfunction was a factor in the lives of all four children, and three of the children experienced chronic childhood neglect.

Learning themes include: ethnicity, intersectionality and adultification; intersection between hypermasculinity, weapon carriage and protection; the victimisation-protection paradox; intersection between intra-familial and extra-familial harm; role of cumulative adversity in driving SYV and the impact on engagement with professionals; absence of fathers; interface between childhood neglect and SYV; children with special educational needs and disabilities (SEND); efficacy of multi-agency child exploitation (MACE) processes and Prevention MACE; recognising the third sector as an equal safeguarding partner; reflecting the voices of peers, parents and carers within contextual analysis and risk assessment; peer mapping; responding to online harms; contextualising cannabis use; educational vulnerability and the pathway to serious harm; and responding to knife crime and SYV within a school context.

Recommendations cover: strategy and governance, relating to contextual safeguarding, knife crime prevention and intervention; risk assessment and response, relating to peer mapping, the use of genograms, intra- and extra-familial harms, and SYV, exploitation and weapon carriage; training and professional development, including an offer to voluntary sector partners; and intelligence and information sharing between strategic education leads and the police.

National policy level recommendations include: the UK Government to explore the national roll-out of Multi-Agency Engage Panels (Youth Futures Prevention Panels); and the Department for Education to consider the development of a clear national strategy to support schools to embed a consistent response to concerns about weapon carriage and use.

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

7. Child safeguarding practice review: Family 1: Child sexual abuse and harm

A child in Family 1 was identified in indecent images shared by their stepfather. When the police went to arrest the man, they had serious concerns about the state of the family home. Subsequent assessments have identified that the children in the family have been exposed to emotional harm and neglect, and several of them have alleged both physical and sexual harm.

Learning themes explore: child protection issues that reoccur; indicators that sexual harm or abuse may be an issue in a family and recognition of behaviour as communication of trauma; the vulnerability of children who are electively home educated; recognising when a parent is not being open with professionals; families that move areas; and the child's place in the system.

Recommendations include: the need to share all available information about a child/ren to all relevant agencies in a new area when they move and there are known vulnerabilities; the partnership to consider how it can highlight and improve consideration of the additional vulnerability of children who have moved; and the partnership to consider the report, 'Understanding and responding to sibling sexual harm and abuse' by Dr Elly Hanson and plan for improved practice.

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

8. Report of the child safeguarding practice review regarding 'Rosie'

Sexual abuse of a 6-year-old girl by her paternal step-grandfather, disclosed in August 2023. Rosie's paternal step-grandfather was a registered sex offender, and a safety plan was in place. Rosie was made the subject of a child protection plan in 2021 due to concerns about neglect. Her mother had intersecting needs, with concerns around mental health, poor literacy, substance misuse, and domestic abuse.

Learning themes consider: importance of identifying all family members and significant adults in a child's life and the need for robust risk assessments; information sharing; importance of robust multi-agency safety plans; challenges for professionals working with children where child sexual abuse (CSA) is suspected but not disclosed; drift and delay in planning for children experiencing neglect; recognising and responding to domestic abuse and coercive control; and recording and meeting the needs of children from Mixed Heritage backgrounds.

Recommendations include: partner agencies to provide assurance that historic practice relating to assessing and sharing risk about known sex offenders is no longer replicated; the partnership to develop practice guidance for professionals working with children where CSA is suspected but not disclosed; the partnership to undertake a multi-agency assurance activity to evaluate the impact of the family connect service within children's services; children's services to complete an internal audit of the effectiveness of its escalation processes; the partnership to evaluate the effectiveness of the neglect strategy and toolkit in improving the identification, assessment, and response to neglect; the partnership to gain assurance that multi-agency practitioners have the skills to recognise domestic abuse and coercive control; and partner agencies to provide written assurance to the partnership confirming that they have implemented procedures to identify and support

parents with intersecting needs and to ensure they are recording children's ethnicity in a consistent way.

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