

NSPCC Repository

September 2026

The NSPCC added eight case reviews to the repository in September featuring issues including child neglect, professional misconduct, parents who have a mental health problem, and gaming

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 executive summary: Examining the multiagency response to Child F and G who were subjected to harm, abuse and neglect

Unexplained injuries to an 18-month-old in 2021 (Child F) and their 7-week-old half sibling (Child G) in November 2023. Following an assessment Child F's name was removed from the Child Protection Register (CPR), and a support plan put in place for the family. The case was closed by Children's Services in June 2023. When Child G was born the children lived with their mother and Child G's father. Child F's father had regular contact with them throughout this time. Child G's injuries included bruising to the scrotum, a skull and a leg fracture. Both children were subsequently placed on the CPR in December 2023.

Learning themes include: child protection procedures and guidance regarding infant bruising; the robustness of risk assessments; decision making; and parents' use of complaints to deter from professional involvement.

Recommendations include: ensure a consistent approach to collaborative, integrated assessments of risk and need through the introduction of an agreed framework across all agencies; ensure a consistent approach to the creation and use of integrated chronologies; consider revising existing learning opportunities for practitioners to understand the complexities of working with families who are struggling to engage; develop learning opportunities for practitioners to ensure male care givers are included within assessments, and in relation to working with families where there have been unexplained injuries to children; update supervision guidance; ensure that learning and training is updated to reflect the findings from this review; and NHS Lothian should explore ways to improve information sharing, particularly in relation to GP's ability to share information electronically with emergency departments.

Other resources Read review online:

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

2. Child Safeguarding Practice Review: Child C

Death of a 1-year-old child in Spring 2022. Child C lived with their parents, who originated from Afghanistan and Iran, and older sibling. Child C's mother was known to have ongoing mental health needs, including schizophrenia and psychosis. She also had limited use of English and a diagnosed learning disability. Child C's father had depression and severe memory problems. A child in need framework was used during the mother's first pregnancy, until the family withdrew consent.

Learning considers: parenting capacity; mental capacity and the ability to consent; discharge planning; assessing safety and risk in the context of intersectionality; cultural competence; and language barriers.

Recommendations for the partnership include: strengthen multi-agency procedures and guidance relating to the critical stage of pre-birth assessments, highlighting the importance of conducting a comprehensive assessment, potentially over a number of visits, to check the consistency of response to assessment questions and an exploration of the parent's areas of vulnerability; further improvement to discharge planning, including a review of policy, procedure, and practice when there are concerns about a child's safety, and consideration about the role of the GP in ongoing health care, post discharge; a review of multi-agency safeguarding procedures to contain guidance about the need to consider and assess intersectionality and multiple sources of vulnerability that may impact parenting capacity, for example, disability, mental health, race and language barriers; promote the use of interpreters across all agencies, especially when risks to children have been identified and require a multi-agency assessment, decision making and safety planning; and support the workforce to understand and assess the differences between learning disabilities and learning difficulties, especially in relation to assessing parenting capacity, mental capacity and consent.

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

3. Child Safeguarding Practice Review: Xavier

Suicide of a 19-year-old young person in September 2025. In early childhood Xavier experienced several changes of primary carers, including mother, father or father's family (out of the UK), and maternal grandparents. In 2019, care orders were made and his grandparents approved as foster carers. This followed a deterioration in his mother's mental health.

Learning themes include: understanding and supporting a child's emotional wellbeing; the impact of adverse childhood experiences (ACEs); suicidality; social anxiety and possible neurodiversity; ethnicity and culture; care leavers, transition to adulthood and transitional safeguarding; and competitive gaming and esports.

Recommendations include: the partnership should commission a review of the training and support given to family, kinship and foster carers looking after children who have experienced significant ACEs so that carers can provide trauma-informed care and recognise possible suicidality; the partnership and adult safeguarding board should commission a review of how services understand and respond to trauma, identity development and autonomy for young people aged 16-25-years-old, and consider a review of the operation of the 'Think Family' approach; children's social care should review its procedures to ensure that adults who do not have parental authority but who have the main caring responsibility for a child have the authority to make decisions in the child's best interests or are able to resolve any differences of opinion considering decisions about the child's needs and care; the local health board and partnership should review the need for a public health response to the benefits and risks of gaming and esports; and the integrated care board and children's social care should give consideration to commissioning a specialist health practitioner to support care-experienced young people aged 16-25-years-old.

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

4. Local Child Safeguarding Practice Review: Child F

Serious safeguarding incident involving a 15-year-old girl in January 2024. At the time of the incident, Child F lived with her father and half-sibling and was being supported by agencies through a child in need (CIN) plan. Child F had previously been the subject of four CIN plans due to unpredictable and neglectful parenting. She had witnessed domestic abuse and some adults who cared for her had a history of vulnerable mental health issues and alcohol misuse.

Learning themes include: effective multi-agency child protection conference processes; responding to the mental health of young people who 'fall in the gap' between services; professional response and safeguarding approach to sexualised behaviour; not relying on children to tell; and identifying and responding to risks that impact on parenting capacity.

Recommendations to partnership agencies include: publish a statement of expectation regarding attendance at initial child protection case conferences (ICPCs) and establish a system to monitor attendance; promote usage of the sexual behaviour screening resource for children and young people across all agencies; take forward the national CSPR recommendations regarding professional knowledge, skills and confidence and evidence this through single and multi-agency audit work; ensure that a core group or family support meeting is triggered when a child open to children's social care is off-rolled from school to be electively home educated; seek assurance that safety plans for children at risk are robust in their assessment of risk; seek assurance that agencies working with parents and carers are encouraged to contribute to the identification of risks which impact on parenting capacity, sharing of information, and multi-agency planning to reduce risks.

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

5. Child Antony: Safeguarding Practice Review

Death of an 8-year-old boy following a serious incident in 2025. Antony had significant additional needs, including autism and communication differences, and lived with his mother and siblings. Antony's mother had long-standing challenges relating to substance misuse and poor mental health, including a diagnosis of emotionally unstable personality disorder. Agencies were involved with the mother over many years and the wider family, particularly Antony's maternal aunt, provided support.

Learning themes include: strengthening understanding of children's needs and parenting ability; transfer/sharing of information; reliance on parental self-reporting; professional curiosity about underlying issues; family support networks; and involvement of drugs and alcohol services.

Recommendations to the partnership include: practitioners must be confident in sharing information with or without consent when it is necessary to safeguard children, and practice should remain open and transparent, with professionals engaging families in honest conversations about consent; ensure all practitioners working with children and adults possess the necessary knowledge, skills and professional confidence to deliver effective interventions with families, including the ability to safeguard every family member, engage in difficult or sensitive conversations, and clearly identify and escalate concerns when children may be unsafe; practitioners working with children and/or adults must offer a whole family approach to assessment, planning and review and children and adults must be seen separately and as part of their home and network; and assessment processes must be revised to ensure that practitioners

explore the circumstances of the whole family, including multi-agency input and the wider support network. Also recommends enhancing safeguarding practices within the drugs and alcohol service.

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

6. Child Safeguarding Practice Review: Neglect

Considers systemic learning and recurring practice issues from three different families that were the subject of Rapid Review meetings.

Learning themes include: the need to seek, share, know and consider a parent's history and vulnerabilities, and understand the impact this will have on their children; children who are electively home educated or have poor school attendance; supporting parents to meaningfully engage with services to benefit their child; responding to information shared anonymously, or by family or friends; the need for contingency planning and multi-agency involvement when a plan ends; the vulnerability of children who move area; the coexistence of neglect with other forms of abuse; and poverty awareness.

Recommendations to the Partnership include: request that a task and finish group is established to complete a piece of work across agencies about how to improve COMPASS referrals, by the inclusion of multi-agency information and concerns, over time, that focus on the impact on the children; consider how they can improve the response, across agencies, to concerning information shared by members of the public; consider how to ensure improved contingency and 'exit' planning, with clear instructions about what should happen when a child closes to Targeted Early Help or Children's Social Care, so that the family and agencies with continued involvement with a child are clear about expectations; and request assurance that any social work assessment includes robust consideration of the information held in Early Help records.

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

7. Thematic Child Safeguarding Practice Review: 'Why doesn't anything change?' Identifying and responding to child neglect in Swindon: Our challenges and opportunities

Sets out learning captured from three recent reviews and recognises learning from three preceding reviews that concerned neglect.

Learning themes include: organisational factors which might have impacted the quality and effectiveness of service delivery since 2020; practice and practice knowledge and systems and processes to strengthen the response to child neglect; and leadership and culture.

Recommendations to the partnership include: review the information relating to neglect available for professionals on the website and develop a communication and dissemination strategy to alert all agencies about changes made; review and update its 'Children's neglect framework and practice guidance' (2026) to include findings from this review as well as review and refresh the tools and approach used for the early identification and assessment of neglect; disseminate its resolution policy to all agencies, services and teams; explore options to implement and embed independently facilitated multi-agency supervision/case discussion, focusing on children who experience persisting neglect with little sustained change over time; promote the use of multi-agency chronologies especially when child neglect is a concern; ensure the safeguarding in education service have necessary access to safeguarding recording databases; undertake work to strengthen information sharing systems and processes between GP practices and statutory agencies;

introduce a system wide multi-agency audit process, that is scheduled and inclusive of practitioners and managers; develop ways of helping everyone to understand their place within the neglect strategy; refresh and strengthen its neglect sub-group work plan to include SMART objectives and a clear work plan that is subject to scheduled independent scrutiny; and establish a safeguarding in education practice sub-group with a clear set of measurable impact aims.

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

[Read learning brief \(PDF\)](#)

Related

[Child safeguarding practice review: Lola: a review examining agency contact with Lola and family.](#)

[Case review]

[Child safeguarding practice review: Liam: a review examining agency contact with Liam and family.](#)

[Case review]

[Child safeguarding practice review: the Willow Children: a review examining agency contact with a large sibling group of children.](#) [Case review]

[Local child safeguarding practice review: 'Tristan'.](#) [Case review]

[Local child safeguarding practice review: 'Bella and Ben'.](#) [Case review]

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

8. Local Child Safeguarding Practice Review: Learning from the past: The use of restrictive practices, including seclusion, in a school for children with additional needs

Analyses the multi-academy trust school's use of restrictive practices, primarily focusing on the use of designated rooms during a three-year period from 2014 to 2017. During this time, 38 children and young adults experienced use of excessive and inappropriate physical restraint, prolonged periods of seclusion and other restrictive and harmful practices whilst being placed in and left alone in these rooms.

Learning themes include: behaviour management and safeguarding, including the use of seclusion; child centred practice; recording and reporting; workforce training; leadership, governance and external oversight; and multi-agency working. Recommends the Child Safeguarding Practice Review Panel asks the Department for Education to publish further clarification on the accountability and oversight between local authorities, regulators, academies, and independent schools in relation to safeguarding incidents to ensure a clear allocation of the duty of safeguarding oversight and intervention where harmful or poor practice is known or suspected.

Recommendations to the partnership include: a multi-agency plan should be established, implemented, and regularly reviewed to respond to the potential trauma experienced by the children subjected to harmful restrictive practices; complete and publish a multi-agency audit of all SEND provision across the borough; education providers should provide assurance to the partnership that workforce induction, training, supervision, and refresher programmes are compliant with current statutory and best practice guidance, consistently delivered, and subject to effective leadership oversight; review and, where necessary, revise behaviour support plans to ensure they are developed and implemented in line with current statutory requirements and recognised best practice guidance; and establish and provide confirmation to the partnership of robust governance and oversight arrangements for safeguarding.

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

