# NSPCC Repository October 2026

***The NSPCC added eight case reviews to the repository in October featuring issues including child sexual abuse, extra-familial harm, malnutrition, and domestic abuse***

***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: Young Person D: Executive Summary of Learning

Death of a 19-year-old from a suspected accidental overdose in January 2023. Young Person D had previously been subject to a child protection plan, had become involved with justice as a young person, and was a looked after child in secure care.

**Learning highlights:** lack of flexible housing and support for young people can exacerbate existing vulnerabilities, particularly for care leavers; there are gaps in mental health services for young people aged 18-25-years-old in crisis; the pathways between children's and adult social care are unclear and there is a lack of understanding of roles and responsibilities of each service; and court processes for young people do not appear to be sufficiently trauma-informed or take account of neurodivergent conditions and learning difficulties.

**Suggested strategies for improving practice and systems include:** sufficient, flexible and age-appropriate supported accommodation that can sustain young people with high levels of need or vulnerabilities in accommodation or tenancies; developing approaches such as transitional safeguarding which takes account of the age and stage of a young person rather than services ringfenced by chronological age or eligibility criteria; increased understanding and better communication between children and adult services including clarity about the implementation and application of Getting it right for everyone (GIRFE) and adult support and protection; explore approaches to young people in conflict with the law in terms of timescales for court decisions and breaches being expedited for under-21s in crisis; consider the learning from the Glasgow Youth Court and its applicability for Edinburgh; and develop guidance on the length of time a young person is away from home and in breach of court orders before contact is made.

Other resources Read review online:
www.edinburgh.gov.uk/downloads/download/14017/edinburgh-child-protection-committee

### 2. Learning Review: Child S

Severe brain injury and skull fracture to a 2-year-old boy in September 2020. The mother initially reported this as the result of a fall from a trampoline but two days later admitted he had fallen from a first-floor window. After a further fall in March 2021 a child protection order (CPO) was

granted, and Child S was placed in foster care; this was the fourth occasion Child S had been on the child protection register (CPR).

**Learning themes include:** child protection registrations and de-registration; dissent and disagreement within child protection case conferences (CPCCs); risk assessments and parenting capacity; referrals to Scottish Children's Reporter Administration (SCRA); seeking views of all children within the family; professional curiosity in unexplained injuries; and impact of the COVID-19 pandemic.

**Recommendations include:** assurance processes should be put in place to formally review children who have had three or more periods of registration within a 24-month period; child protection plans must be SMART; all health records should have alerts for children who are or who have been on the CPR; guidelines for CPCCs should include clear expectations of all agencies and all professionals; reports should be submitted with relevant and accurate information in advance of meeting to support robust decision making; processes for dissent should be clear for all agencies including decision making and outcomes of CPCCs; health professionals should clearly note and share any concerns about parental engagement, presentation or emotional availability; the views of all children within the family should be clearly recorded within agency records and assessments; and all significant unexplained injuries should be thoroughly investigated to ensure concerns about neglect are identified.

**Other resources** Read review online: [www.glasgowchildprotection.org.uk/article/5337/Learning-Reviews-and-Learning-Packs](www.glasgowchildprotection.org.uk/article/5337/Learning-Reviews-and-Learning-Packs)

### 3. Child Safeguarding Practice Review: Daéjaun Campbell

Murder of a 15-year-old boy in September 2024. Prior to his death Daéjaun's mother had sought help regarding missing episodes, cannabis use, suspected drug dealing, association with risky peers and possession of weapons.

**Learning themes include:** information sharing between multi-agency professionals; the response to missing episodes and extra-familial harm; the role and impact of men and fathers; substance misuse; and the child's voice, ethnicity, and identity.

**Recommendations to the partnership include:** seek assurance that multi-agency arrangements ensure timely information-sharing, coordinated safeguarding planning, reduced turnover of the allocated family help worker and effective risk management for children experiencing extra-familial harm; seek assurance that relevant agencies have established explicit joint intelligence-sharing protocols and named lead accountabilities at both operational and strategic levels; ensure that children presenting with substance misuse linked to exploitation risk receive early intervention and timely referral to specialist services; seek assurance from the police that when a child is reported as missing all relevant information, intelligence, and identified safeguarding risks obtained at the first point of contact are consistently recorded, with compliance evidenced through regular auditing and reporting to the partnership; review cross-borough housing pathways to ensure families experiencing extra-familial harm can access relocation support where safeguarding risks are present; strengthen multi-agency systems for analysing peer networks and contextual risk, including the use of peer mapping and intelligence-sharing forums; support training for GPs on identifying and responding to indicators of criminal or sexual exploitation in adolescents; ensure

safeguarding assessments explicitly analyse how a child's race, ethnicity, identity and experiences of discrimination influence vulnerability and engagement; and ensure that adolescents' voices are interpreted through trauma-informed and exploitation-aware practice.

**Other resources** Read practice review (PDF)

### 4. Child Safeguarding Practice Review: Mabel

Sexual assault of a 15-year-old adolescent. Police attended Mabel's family home in July 2025 after notification by the National Crime Agency that Mabel had been uploading indecent images of herself to the internet. During the police visit, Mabel disclosed 'being in a sexual relationship' with a 30-year-old male who she had recently discovered was working in a position of trust. Mabel was sexually assaulted by a family member when she was approximately 6/7-years-old and there were significant concerns about their mental health following overdoses and suicide attempts.

**Learning themes include:** supporting shared understanding of early childhood trauma when considering presenting risks later in a child's life around their mental health, emotional wellbeing and emerging risks of sexual exploitation and grooming; cumulative effect of harm; harm outside the home processes; and supporting parents and children to understand the impact of trauma on future risk and vulnerability.

**Recommendations to partnership agencies include:** seek assurance that all children are being assessed and safeguarded when safeguarding concerns are reported and provide assurance that all children in the family are considered in assessments; review multi-agency training that is offered to professionals in understanding cumulative risk, harm and vulnerability; be assured that agencies are supporting parents to effectively safeguard children when the threshold has not been met for statutory service involvement; and consider utilising multiagency partners/trusted professionals to support families in recognising vulnerability and addressing risk when there is no role for statutory services.

**Other resources** Read practice review (PDF)

### 5. Local Child Safeguarding Practice Review: Child K1

Admission to hospital of a 19-month-old child in February 2025, presenting with hypothermia, hypoglycaemia, malnutrition and severe dehydration. Child K1's mother was 17-years-old when she became pregnant and was supported by her mother and aunt in the care of Child K1. During an earlier hospital visit it was noted that Child K1's weight had dropped significantly, and there were two referrals relating to concerns of neglect. Child K1's mother had experienced sexual abuse and there were concerns around her mental health, non-engagement with services, and possible SEND.

**Learning points include:** the need for increased professional curiosity to establish the lived experience of the child, by exploring who is providing care for a child, such as the wider family network, and whether there are indicators of neglect; the need to seek supervision when the actions or inactions by parents and carers are preventing or making it difficult for practitioners to practice in line with policy; greater emphasis to be placed on retrieving historical information,

including information from education services, at the start of a service's involvement to ensure information isn't lost as children transition into adulthood and/or move across geographical areas and services; the importance of managerial oversight in guiding frontline social workers and ensuring action on plans have been completed prior to case closure; the importance of sharing all relevant information at strategy meetings and maintaining focus on the concerns that led to the meeting being held; and the need to establish the root cause of faltering growth identified in children.

**Recommendations are embedded in the learning.**

**Other resources** Read practice review (PDF)

### 6. Child Safeguarding Practice Review: Safeguarding babies/infants where parental mental health and domestic abuse feature

Neglect and physical abuse of two unrelated infants. Child SA was under 1-years-old when they became seriously unwell following neglect. Child SB was an 8-week-old who died while living with their parents; several injuries were found during the post-mortem, including fractures to the skull, clavicle and leg. In March 2026, the mother of Child SB was convicted of their murder.

The review considers systems and practice relating to both incidents and where there are predisposing or emerging vulnerabilities and risks.

**Learning themes include:** the need for professionals to understand different types of domestic abuse within families and to also consider other issues that can impact on children; the availability of specialist work programmes for victims and perpetrators of domestic abuse and their children; the involvement of extended families when families require support; information sharing about adults who seek help with difficulties controlling their anger; pre-birth assessments; and professional challenge.

**Recommendations to the partnership include:** request assurance from the local NHS trust regarding the progress of the improvement actions being undertaken with maternity services in respect of safeguarding supervision and the quality of multi-agency referral forms; ask all agencies to promote the unborn baby network and request assurance that this has happened; ask the domestic abuse strategic partnership to clarify what support is available to perpetrators of domestic abuse and consider how this can be communicated to professionals working with children and families; and undertake a piece of work to consider the obstacles to professional challenge and escalation of professional disagreements.

**Other resources** Read practice review (PDF)

### 7. Child Safeguarding Practice Review: The sexual abuse of children living outside of their birth families: Coco

Reports of rape and sexual abuse from a 13-year-old girl against her male carer in 2020. The criminal investigation took five years to conclude; in 2025 the carer was found not guilty. At the

time Coco lived with her foster carers on a special guardianship order (SGO) with her younger sibling.

**Learning themes include:** the risk of abuse and neglect of children in care or SGO placements; the importance of relationships with professionals for children living outside of their birth families; understanding a child's lived experience; identifying, understanding and responding to adult behaviours that might indicate they pose a sexual risk to children; responding to a child when they make a report of sexual abuse; and the need for effective and timely criminal investigations that support children and young people.

**Recommendations to the partnership include:** consider the offer of an 'exit interview' for care leavers, as an opportunity to reflect on their experiences of the care system; consider how all schools are supported and aware of their responsibilities to children who were previously in care but are now on SGOs or adopted; review current processes for children previously looked after and subject to unsupported SGOs to ensure these children are supported through a time-limited, multi-agency child in need plan, which includes robust step-down arrangements to universal services, particularly where the SGO was contested by the local authority; and the police should provide written assurance that, if Coco were to present today, her experience as a victim would be demonstrably different, reflecting changes to the investigation and management of sexual abuse cases since 2019.

**Other resources** Read practice review (PDF)

### 8. Local Child Safeguarding Practice Review: Cooper and Harris

Considers the experiences of two teenage brothers following the death of their mother at home in February 2025. Attending professionals identified severe examples of neglect and poor home conditions. The mother had physical and emotional health needs, including poorly controlled diabetes, and there were concerns around domestic abuse involving the children's father and the mother's subsequent partners. A period of children's services intervention ended in 2023.

**Learning considers:** the cumulative impact of domestic abuse on children; parenting roles in the context of domestic abuse; pressing adult needs and the visibility of children; children masking distress; cumulative child neglect; housing insecurity and poor living conditions; hidden caring roles and adultification; poor visibility across health systems; identification of hidden parental vulnerabilities; information-seeking and curiosity across services; and exploring the wider family context.

**Recommendations include:** strengthen multi-agency practice in recognising hidden and passive neglect by ensuring practitioners are equipped to identify when children have adapted to unmet needs and present as resilient or self-sufficient; ensure the identification of young carers and promote multi-agency support pathways, ensuring that children's caring roles are recognised early and improve professional recognition of adultification among adolescents; ensure that housing issues, including overcrowding, are consistently recognised as drivers of neglect and cumulative harm, and seek assurance that housing providers understand their role within whole-family safeguarding; the partnership and adult's board to provide strategic leadership and seek assurance on the consistent implementation and impact of its Think Family/Family Help approach across adult and children's systems and practice; and the partnership and adult's board to strengthen

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| system-wide multi-agency understanding of parental adversity, family functioning and neglect by ensuring the organisational conditions are in place to support critical, reflective and analytical practice across adult and children's services.<br><br>**Other resources** Read practice review (PDF) |
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