NSPCC Repository November 2026

The NSPCC added eight case reviews to the repository in November featuring issues including child neglect, infanticide, suicide, and children who have chronic illness

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. **Child safeguarding practice review: a focused thematic review examining the response to child neglect in Bedford Borough through the lives of seven large sibling groups, including the Jabril children.**

   Long term neglect of a large sibling group who were removed from their parent's care in 2025. Prior to removal, concerns related to the children being unclean, school attendance, poor home living conditions, resistance from the children's mother to engage with professionals and mental health concerns for two of the children who were morbidly obese.

   Examines the Jabril children alongside six other large sibling groups where chronic neglect had been identified.

   Learning themes include:

   Consideration of cumulative harm; parental engagement; parental self-reporting and work with consent; use of assessment tools to gather information; multi-agency collaboration and information sharing; professional curiosity, challenge and escalation; consistency of thresholds, risk assessment and decision-making; using children's views to inform decisions; assessment of culture and intersectionality; assessment of fathers/adult males; and the management of transitions.

   Recommendations to the partnership include:

   Strengthen decision making and earlier identification of cumulative harm due to neglect; take a whole-family approach, with a focus on every child's lived experience; treat persistent parental non-engagement as a safeguarding risk indicator; improve assessment, planning and review through consistent use of tools, chronologies and measurable outcomes; strengthen professional challenge, escalation and management oversight; improve the effectiveness and impact of strategic neglect arrangements; provide clearer leadership and coordinated multi-agency responses for large sibling groups; and improve support for practitioners working with complex and chronic neglect cases.

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

2. **Learning Review: Child S**

Death of an infant under 3-months-old. Child S was subject to a child protection plan at the time of their death. A postmortem examination established that they had several injuries consistent with being 'non-accidental'.

Learning includes:

The safeguarding system pays insufficient attention to fathers and male carers; practitioners need the knowledge, skills and confidence to ask the right questions and work effectively with culturally diverse families; a fuller understanding of risk could have been achieved through utilisation of expertise across the whole network; safeguarding children procedures need to be understood and used as "live" documents; and to maintain positions of 'safe uncertainty' practitioners need structured space to reflect individually and collectively on the evolving nature of dangers to children.

Recommendations include:

Ask partner agencies to set clear expectations about the involvement of male carers in their work with children and provide evidence of positive engagement with men in the system; demonstrate a commitment to culturally competent practice; re-establish the importance of multi-agency assessment and ensure that all practitioner voices are heard; understand the impact of multiple births on a family and include this as a factor when assessing risk and establishing the nature of family support needed; review the role of substance misuse services and adult mental health services within the child protection assessment and planning processes; promote a positive approach to the use of escalation procedures; and understand and remove any actual or perceived barriers to multi-agency reflective discussions.

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

3. Significant case review: Child H.

A 15-week-old boy was presented to the emergency department of the hospital with an arm injury in April 2019. Investigations identified 14 other fractures including skull, all four limbs, rib fractures and a brain injury. When he was presented three of the older children were subject to Compulsory Supervision Orders (CSO) due to poor school attendance, domestic violence and lack of parental care.

Learning includes:

The pre-birth assessment and the multi-agency response needs to be consistent to identify and effectively manage vulnerable pregnancies; professional understanding of domestic abuse; general case management and practice; thresholds and multi-agency relationships; and professionals recognising and responding to neglect.

Recommendations include:

Pre-birth processes should reassess the risks and needs for each child within the family network and any accumulative impact of a new baby within the family; it is vital that the full range of information in relation to domestic abuse is included in all multiagency meetings and assessments; all agencies should ensure that they have appropriate escalation and dissent processes when they have child protection concerns about children; and regular quality

assurance processes should be in place both for each agency regarding quality of chronologies and assessments.

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

4. Child Safeguarding Practice Review: Mabel

Severe neglect of two siblings aged 6-years-old and 7-years-old, who were removed from their home under police protection in February 2025. The children had been in the sole care of their mother since 2020. They were electively home educated from the outset of their schooling, and services in Hounslow were largely unaware of their existence. Their parents were separated and there had been reports of domestic abuse perpetrated by the father.

Learning considers:

Domestic abuse; children's front door responses; critical thinking, assessment and decision making; voice of the child; elective home education; access to services out of area; safe transitions between services; impact of virtual working practices; and intersectionality.

Recommendations to the partnership include:

Complete a multi-agency audit of the effectiveness of MASH processes in ensuring the child's voice is central to the risk assessment, confirming information is routinely taken from a number of sources to inform assessment and decision making, ensuring both parents have been consulted, and ensuring management oversight is evident; develop resources to assist practitioners' understanding and application of professional curiosity; prioritise issues arising from intersectionality and establish a regular programme of multi-agency reflective workshops in safeguarding practice; offer a briefing pack to practitioners to increase awareness of elective home education, which includes information from the new legislation (when available), parental rights and professionals' responsibilities in regard to sharing information; oversee a review of the information sharing pathway between health visiting and school nursing services for vulnerable children; and share learning with the local adult safeguarding board.

Other resources Read practice review (PDF)

5. Thirlwall Inquiry: report of the Public Inquiry into events at the Countess of Chester Hospital, 2015 to 2018: summary report and recommendations.

Examines events at the Countess of Chester Hospital and their implications following the convictions of former neonatal nurse Lucy Letby of murder and attempted murder of babies at the hospital. The report finds that the collapse and deaths of some babies could have been avoided had safeguarding practices been followed and calls for urgent reforms to practices in the operation and supervision of NHS neonatal units.

Learning is embedded in the recommendations. Makes 17 recommendations covering:

CCTV and monitoring; safeguarding and contracts of employment; data reporting; sudden unexpected death in infancy and childhood (SUDIC); suspicion of deliberate harm protocol and guidance; medical examiners; and accountability and regulation of managers.

Recommendations include:

All cots and incubators in all neonatal units should be fitted with baby monitors so that parents can observe their baby remotely at any time; all Trusts must provide safeguarding training to all staff (appropriate to their role and expertise) and Board members, including Non-Executive Directors and this training should include how to deal with concerns and suspicions about deliberate harm caused by staff; NHS England must produce and distribute a one-page protocol setting out the steps to be taken by managers when concerns or suspicions are raised that a healthcare professional may have deliberately harmed a patient; and every existing contract of employment for work in an NHS hospital must be amended to include an obligation on the employee to follow all relevant safeguarding guidance, including the Suspicion of Deliberate Harm Protocol for dealing with concerns and suspicions about deliberate harm.

Other resources **Read summary report and recommendations (PDF)**
View the full inquiry: **thirlwall.public-inquiry.uk/**

6. Child safeguarding practice review: Jamilia.

Suicide of an adolescent girl. Jamilia originated from a war-torn country and arrived in the UK with her family as refugees. She became a child looked after in September 2023. Prior to her death there were incidents of self-harm and warning signs of exploitation, including online contact with an older male. Jamilia had experienced significant childhood trauma, including physical and sexual abuse.

Learning themes include:

Culture and past harm; language in respect of child exploitation; children affected by self-harm and suicidal ideation; the impact of domestic abuse; responses to child sexual abuse; online vulnerability and harm; working with complex high-risk children; engagement and relationship building; placement moves; and trauma-informed practice.

Recommendations include:

Children's plans must clearly evidence multi-agency actions that come from comprehensive, culturally aware assessments and follow up actions from specialist reports; practitioners should delve deeper to create a meaningful understanding that links past experiences and family culture to current concerns; establish mechanisms to oversee the elimination of 'child-blaming' terminology across the multi-agency network but more specifically the police; consider engaging with the resettlement team to review practice and develop future responses to the resettlement of refugees; the commissioning process needs clinical oversight regarding what a placement is offering and how it meets a child's specific therapeutic needs; agencies to consider how to improve consistency and information sharing when children are placed out of borough and when moving to different placements; ensure that multi-agency practitioners are equipped to recognise and respond to self-harm and suicide with clear

mental health thresholds and pathways; and multi-agency managers need to evidence proactive oversight.

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

7. Child Safeguarding practice review report: Amma.

Death of a teenage girl in 2024 after suffering a severe asthma attack. There were concerns about Amma's home environment preceding her death.

Learning themes include;

The application of a Think Family approach; interprofessional communication; consideration of ethnicity, culture, and diversity within assessments and decision-making; capturing and interpreting the child's voice; leadership, oversight and multi-agency culture; service pressures, health inequalities, and gaps in preventative provision; and cumulative risk and environmental factors.

Recommendations to the Partnership include:

Ensure that all practitioners consistently assess and document children's lived experience; ensure health services recognise that repeated emergency presentations, missed appointments, medication non-adherence, or inconsistent engagement are indicators of cumulative risk and trigger timely safeguarding discussion; ensure practitioners across partner agencies recognise poorly managed asthma as a potential safeguarding concern; assess whether agencies consistently follow their safeguarding supervision and managerial oversight policies; ensure that anti-discriminatory practice is embedded across assessment and intervention; work with partner agencies to jointly develop and implement a Think Family Approach Protocol which sets out clear procedures for information sharing, joint assessment and coordinated support for families with complex needs; ensure their escalation protocol and routes for professional challenge are clearly understood and consistently applied; ensure training addresses how partner agencies identify, assess and provide support to Young Carers; ensure services jointly implement action to address systemic barriers to healthcare access for families from lower socio-economic backgrounds. Also suggests that The Child Safeguarding Practice Review Panel should consider recommending that the national legal framework for private rented accommodation is strengthened to enable faster, enforceable action where damp, mould, or other hazards place children's health at risk.

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

8. Local child safeguarding practice review: Child SH

Murder of a 10-year-old girl by her mother in March 2024. Child SH and her mother had had contact with several agencies since January 2023. While there were concerns about Child SH's care, there were no indications that her mother would violently assault her.

Learning themes include:

Understanding that school absence (whatever the length) can be indicative of educational neglect and of wider safeguarding concerns; understanding the significance of regression in older children; understanding the full context, root cause and effect of school absence; recognition of the significant vulnerability for children who have no family or social network outside the family home; knowing how to proceed when there is no parental engagement and no consent given and there is uncertainty about whether there are safeguarding concerns; the sense of a hierarchy of professionals in evaluating concerns; the ability to reflect on cases that do not fit the usual patterns; the need to focus on parents' needs and voices and their view of their child as much as focus on the child; combatting responses being constrained by what services practitioners know are on offer; the influence of weak legal powers on how agencies respond when dealing with a child missing school; timeliness of action and how urgency can be lost as there are delays in responses; how Signs of Safety is used to inform decision making; the importance of having a multi-agency plan and of evidence-based decision making where new interventions are being implemented; ensuring that there are clear expectations set if a multi-agency meeting is convened about a child; and the importance of meeting notes being shared with participants in a timely way.

Recommendations are embedded in the learning.

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