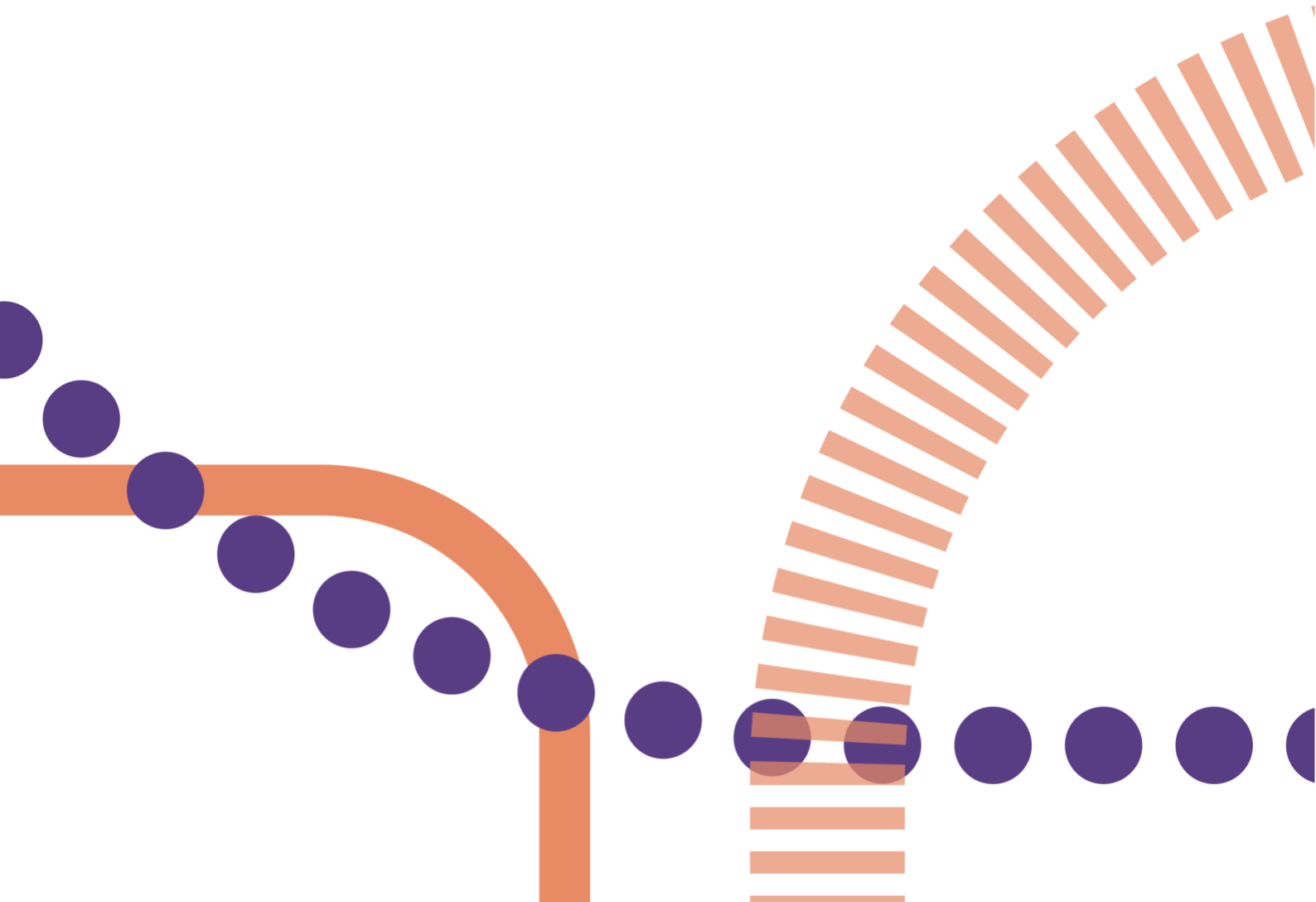
THE CHILD **SAFEGUARDING**
PRACTICE REVIEW PANEL

Safeguarding children from online harms

Online harms and suicide

November 2026



Introduction

The Child Safeguarding Practice Review Panel recently welcomed and responded to Growing up in the online world: a national consultation and supports the Government's ambition to ensure children's experiences online are as safe, supportive, and developmentally appropriate as possible.

The Panel acknowledges the importance of ensuring that all children and young people have access to and understand the growing benefits of technology and hopes the consultation will result in appropriate safeguards to ensure access is age and content appropriate.

As set out in the Panel's core paper on Online harms as a cross-cutting safeguarding risk, online environments are increasingly featured within the context of serious harm to children and young people. The Panel also recognises the importance of supporting practitioners, who often report feeling less confident navigating children's digital lives than they are in assessing risk in a physical setting. Strengthening professional capability in the assessment of digital safety, alongside recognising that children may operate in largely unsupervised online environments, will be increasingly critical to effective safeguarding practice.

As set out in the Panel's core paper on Online harms as a cross-cutting safeguarding risk, online environments are increasingly featuring in the context of serious harm to children and young people.

This paper focuses specifically on suicide and self-harm, where safeguarding reviews highlight how online activity can influence children's emotional wellbeing, relationships, and vulnerability. The Panel sees only a proportion of child suicides in the context of abuse and neglect. The numbers are small, but the learning is significant. Further learning and resources related to adolescent suicide are also available on the Panel's website.

The learning in this paper relates to circumstances where children have been harmed or have died, including where suicide was the likely cause of death, and online activity may have been related to the child's emotional distress.

Serious harm can occur in unseen digital spaces. Suicide risk may also be hidden, rapidly escalating, and influenced by factors not immediately visible to practitioners, particularly within children's online lives. Safeguarding practice must therefore include active exploration of online activity when considering emotional wellbeing and mental health needs.

Who is this document for?

Multi-agency practitioners and managers working in universal services such as schools, colleges, further and higher institutions, health services, police, and social care settings as well as relevant voluntary organisations and services working with adolescents.

This includes practitioners who are responsible for identifying and responding to safeguarding concerns, and who play a role in understanding how online activity may influence children's emotional wellbeing and contribute to suicide risk.

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How to use this resource

> *"We need a system that recognises online harm early, responds to it collectively, takes responsibility away from families and continues to protect and support children for as long as the harm and its effects remain."*
>
> Parent of a child who experienced online harms

Multi-agency practitioners should use this resource as a practical guide to strengthen their approach to identifying and responding to safeguarding concerns where online activity may be contributing to harm, including concerns relating to emotional wellbeing, self-harm or suicide risk.

This learning resource can be used by practitioners, managers and leaders in supervision, team discussions and learning events to reflect on safeguarding incidents where online activity and suicide risk are present, and to support a more coordinated multi-agency practice response.

This resource should be used to support practitioners to recognise how online experiences may influence emotional wellbeing and suicide risk, to identify concerns at an early stage, and to respond through timely information sharing, risk assessment and multi-agency safeguarding action

Why is it important for children and young people?

As highlighted in the Panel's core paper, online harm is increasingly featuring within children's lived experiences and often interacts with wider vulnerabilities.

Safeguarding responses should fully consider how online harm, emotional distress, and the child's lived experience may combine and increase the risk of suicide.

Suicide risk in children can be hidden, rapidly escalating and influenced by online harm. Safeguarding practice should therefore include proactive enquiry, holistic assessment and greater understanding of how digital activity may influence risk.

This includes recognising that early indicators of distress or suicide risk may be present in children's online activity, relationships, and behaviour, and should prompt timely safeguarding and multi-agency responses.

> *"I also feel the emotional and psychological impact of online harm can be overlooked. The effect on a child does not always fit neatly into a threshold or present in a way that is immediately obvious."*
>
> Parent of a child who experienced online harms

Children may also be experiencing online harms that can cause significant and immediate distress, escalating their risk of suicide, including intimate image sharing or demands for money. Practical interventions, such as support to remove content from the internet, should be considered alongside addressing wider safeguarding concerns.

This resource is intended to support practitioners to feel more confident in understanding, identifying, and responding to suicide risk in a digital context, where harm may not be immediately visible.

What is the evidence base?

The Child Safeguarding Practice Review Panel's Annual Report (2024 to 2025) identified online harms as an emerging trend, with an online context reported in 9% (24) of the 274 rapid reviews received by the Panel during the year.

Online contexts, both directly relating to the incident and within the child's life, are increasingly featured within safeguarding reviews considered by the Panel. Numbers of relevant reviews have increased from 5% in 2022-23, to 7% in 2023-24 and 9% in 2024-25.

Of the relevant twenty-four rapid reviews in 2024-25 that noted an online context:

- 58% (n=14) involved incidents of serious harm, particularly extra and intrafamilial child sexual abuse
- 29% (n=7) were fatal incidents, with suicide identified as the likely cause of death in 4 of those 7 cases
- 13% (n=3) were for "other" incidents

Within these cases, safeguarding reviews indicate that suicide and serious self-harm may be associated with a complex interaction between emotional vulnerability, life experiences, and online activity.

Online environments may influence risk through exposure to harmful content, content encouraging suicide, online relationships, social pressures, or experiences of harassment and abuse. These factors often interact with existing vulnerabilities rather than acting in isolation.

Learning from the Panel's national and thematic reviews consistently shows that online environments feature strongly in the experiences of children who have suffered serious harm, particularly in relation to:

- Child criminal exploitation (CCE) – where online platforms are commonly used for grooming, recruitment, coercion, and control
- Child sexual abuse (CSA) – where online spaces frequently function as sites of grooming, sexualised communication, and image sharing
- Neglect – where unmet emotional needs may increase children's vulnerability to harmful online interactions
- Suicide – where children's online relationships and interactions can lead to manipulation, coercion or exposure to harmful content, increasing the risk of suicide

Further detail on the wider cross-cutting role of online harm, including prevalence and system-level findings, is set out in the Panel's core online harm paper.

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Key facts and figures (suicide and online harms)

Between 1 April 2024 and 31 March 2025, the Panel received 274 rapid reviews. Of these, 24 (9%) featured an online context.

Further data (***unpublished)*** from 1 April 2025 to 31 December 2025 highlights that from 216 rapid reviews seen by the Panel, 29 (13%) reported online harms.

Suicide

1 April 2024 to 31 March 2025

Of the twenty-four rapid reviews which featured online harms, 7 (29%) involved the death of a child. In 4 of those 7 fatal cases, suicide was identified as the likely cause of death.

1 April 2025 to 31 December 2025

Of the twenty-nine rapid reviews which featured online harms, in 14 (48%) the child had died. In nine of those incidents where the child in focus had died (64%), the likely cause of death was suicide.

Common issues

Analysis of safeguarding reviews in which online harm featured alongside suicide identified the following common issues:

- **Lack of multi-agency visibility of online harm and suicide risk.** Practitioners across different services often held partial information and were not always aware of each other's involvement or the full range of concerns. In some cases, the child's online activity—central to the events leading to suicide—was not known or understood across agencies. As a result, no single agency had a complete understanding of how online harm and suicide risk combined.

- **Online harm not recognised as a safeguarding risk in suicide**. Where online relationships or interactions played a significant role, these were not always explored within assessments or interventions. Online harm was not routinely integrated into suicide risk assessment, despite its potential influence on behaviour and emotional wellbeing.

- **Lack of professional curiosity about online harm and suicide risk**. Practitioners often focused on presenting emotional needs and did not routinely ask about online relationships or digital interactions. In some cases, children appeared open about aspects of their lives, yet their online experiences remained unexplored. Practitioners relied on disclosure rather than proactively exploring online contexts.

- **Absence of routine digital risk assessment in suicide cases.** Online safety was not consistently considered within safeguarding or mental health assessments. Practitioners did not routinely explore online relationships, potential manipulation or coercion, or exposure to harmful content or content encouraging suicide. Digital contexts were not consistently considered within suicide prevention practice

- **Online indicators were not always fully incorporated into suicide risk assessment**. Information about distressing thoughts, images or content online was not always considered alongside the child's presentation and wider circumstances when assessing suicide risk,

- **Fragmented understanding of emotional and mental health needs.** Children were known to services for emotional distress, self-harm, or vulnerability. However, assessments often focused on presenting symptoms rather than underlying drivers. Links between emotional wellbeing and external influences, including online experiences, were not consistently explored.

- **Fragmented understanding of suicide risk.** Where children presented with distress, risk was sometimes assessed as moderate or manageable without full exploration of cumulative or hidden factors. Suicide risk was often assessed based on presentation alone, rather than on a holistic understanding of vulnerability, potential online influence, and the potential for risk to escalate rapidly.

Across these cases, online experiences, emotional distress and underlying vulnerabilities were not always fully considered together when assessing suicide risk.

Following a child's death, preserving their online information is critical to understanding whether digital experiences contributed to the harm. The Online Safety Act 2023 introduced Data Preservation Notices, enabling Ofcom to require online platforms to retain relevant information for coronial investigations.

Hallmarks of good practice

Analysis of safeguarding reviews highlighted the following examples of good practice:

- **A strong reflective practice and learning culture**, including honest identification of missed opportunities, systemic gaps, and the development of training and awareness programmes. This supported clearer learning about the interaction between online harm and suicide risk.

- **Awareness of hidden risk and non-linear pathways to suicide.** Practitioners recognised that children may appear settled, positive, or future-focused, while underlying risk may be escalating and not immediately visible.

- **Recognition of online harm as relevant to wellbeing and integral to suicide risk.** Online relationships, digital environments, and potential coercion or influence were understood as contributing to emotional distress and vulnerability, rather than being viewed as separate issues.

- **Recognition of emotional vulnerability and context.** Effective practice included understanding trauma, relationships, identity, and life experiences as drivers of distress and potential suicide risk, rather than focusing only on presenting symptoms.

- **Availability of therapeutic and emotional support.** Children had access to counselling, CAMHS and other therapeutic services, supporting both emotional

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wellbeing and recovery. Early support acted as a protective factor, even where risk remained complex.

- **Integration of online activity into assessment and support**. In strong practice, practitioners actively considered children's online lives alongside emotional wellbeing, ensuring that risks within digital contexts were explored and incorporated into safeguarding and mental health responses.

These examples demonstrate that effective practice in cases involving suicide and online harm requires practitioners to take active and specific steps to understand children's digital lives, recognise hidden and escalating risk, and respond through timely and coordinated multi-agency safeguarding action.

Reflective questions for practitioners

Understanding suicide risk

- What do I know about this child's current emotional state and suicide risk beyond what they are telling me?
- Could this child be minimising, masking or unable to articulate suicidal thoughts or distress?
- Have there been any recent triggers or significant events (online or offline) that could increase suicide risk?

Exploring online harm

- What do I know about this child's online relationships and interactions?
- Could online interactions or relationships be influencing their emotions, behaviour or suicide risk?

Professional curiosity

- Have I proactively asked about online activity, or am I waiting for the child to tell me?
- What might this child be experiencing that they are not yet ready or able to disclose?

Linking risk factors

- Have I connected emotional distress, self-harm or thoughts of suicide, and online activity into a single risk picture?

Multi-agency working

- Do other practitioners know what I know about this child's emotional wellbeing, suicide risk, and online use so that we have a shared understanding of risk?

Reflective questions for leaders

- How assured are we that online harm is consistently recognised, explored, and incorporated into safeguarding, mental health, and suicide risk assessments across all services?
- Are all multi-agency practitioners aware of the types of websites that children are accessing and is the partnership sharing national alerts on inappropriate websites from the National Crime Agency (NCA)?
- Do practitioners have the confidence, skills and professional curiosity to identify hidden distress, explore children's online experiences and recognise the potential impact of digital relationships, coercion and exploitation on wellbeing and suicide risk?
- Do practitioners have access to appropriately focused training and clinical supervision?
- How effectively do our systems bring together information from all agencies to create a complete and shared understanding of a child's risk, ensuring that no service is working with only part of the picture?
- Are our approaches to early identification, assessment, and intervention sufficiently responsive to the ways suicide risk can emerge, escalate, or be influenced through online activity, hidden vulnerabilities, and rapidly changing circumstances?
- What assurance do we have that learning from reviews is leading to measurable improvements in frontline practice, workforce confidence, information sharing, and the identification and management of digitally enabled risk?

Case study

An 11-year-old girl was known to services primarily due to emerging emotional and mental health needs, including episodes of distress and self-harm.

The child was described as engaging positively with practitioners and maintaining relationships within school and family, often presenting as settled and future-focused. However, alongside this, there were underlying vulnerabilities linked to emotional wellbeing, identity, and life experiences, which were not fully understood in the context of escalating suicide risk.

Critically, aspects of the child's online activity and digital relationships were not fully known or explored, meaning that potential influences on their emotional state and behaviour were not incorporated into safeguarding assessments. The child's death by suicide highlighted how risk can remain hidden, rapidly escalate, and be shaped by factors not immediately visible to practitioners, particularly within their online world.

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Learning points

- **Online activity must be routinely explored when considering suicide risk.** The child's online life was not fully understood, limiting awareness of how online harm may have contributed to risk.
- **Suicide risk can be hidden behind a positive presentation.** The child appeared settled, engaged and future-focused, contributing to an underestimation of risk.
- **Practitioners should not rely solely on verbal reassurance.** Practitioners should not reduce professional vigilance solely because a child reports no suicidal intent, particularly where vulnerabilities or other concerns remain.
- **Professional curiosity needs to go beyond presenting issues.** Emotional distress was known, but there was limited exploration of underlying factors, including possible online influences.
- **Consider cumulative and contextual factors.** Emotional wellbeing, life experiences, environmental influences and online activity should be considered together to build a fuller picture of risk.
- **Recognise the potential for rapid escalation.** Suicide risk may escalate without clear or observable changes in behaviour.
- **Connect information across agencies.** Where services hold different pieces of information, these need to be brought together to form a shared understanding of risk.
- **Include digital contexts in suicide prevention and safeguarding.** Online activity and relationships should form part of safeguarding responses where they may be influencing emotional wellbeing or suicide risk.

Where can I find out more?

Find more information and resources on the Child Safeguarding Practice Review Panel Learning Hub.

Other useful resources include:

- Child Safeguarding Practice Review Panel: Annual Report 2024 to 2025
- Growing up in the online world: a national consultation
- National analysis of police-recorded child sexual abuse and exploitation crimes: 2024
- The Southport Inquiry: Phase 1 report
- Southport Inquiry: Phase 2 terms of reference
- NSPCC: Online abuse and bullying prevention guide
- Local Government Association: Online harms
- UK Safer Internet Centre
- NCA-CEOP: Guidance, policy and research for professionals