THE CHILD
SAFEGUARDING
PRACTICE REVIEW PANEL

Annual Report 2022/23

Patterns in practice, key messages and 2023/24 work programme

January 2024

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Contents

Evidence Base

1. Primary Sources

- **Serious incident notifications (SINs)** are made by local authorities to the Child Safeguarding Practice Review Panel and Department for Education when a child has died or is seriously harmed, and abuse or neglect is known or suspected. Data for the SINs covers incidents that progressed to a rapid review and occurred during the 15-month period of January 2022 to March 2023 with a focus on the 12-month period of April 2022 to March 2023.

- **Rapid reviews** are conducted for each notification unless further review has identified that there was no neglect or abuse present, in which case the partnership should confirm their reasons for deciding that there are no concerns regarding known or suspected neglect or abuse in relation to the child or that the child has not suffered significant harm. A rapid review is undertaken by local safeguarding partners with the written report to be submitted to the Child Safeguarding Practice Review Panel within 15 working days of the incident notification. The purpose of the rapid review is for partners to identify, collate, and reflect on the facts of what happened as quickly as possible to establish whether there is any immediate action needed to ensure a child's safety. The rapid review will also identify potential practice learning, including deciding whether to undertake a Local Child Safeguarding Practice Review. Data for the rapid reviews covers incidents that occurred during the 12-month period of April 2022 to March 2023.

- **Local child safeguarding practice reviews (LCSPRs)** are undertaken to provide learning to improve safeguarding practice at a local and national level and to avoid similar incidents occurring in the future. There is an expectation that these reviews are completed, submitted, and published within 6 months of the rapid review. Data for the LCSPRs covers reports produced during the 15-month period of January 2022 to March 2023.

- **Letters from the Panel to safeguarding partnerships** following the Panel's consideration of the rapid review. These letters will often provide feedback on the quality of the review and state our position on the recommendation of whether an LCSPR is required or not. Letters used to assess the quality of rapid reviews cover incidents that occurred during the 12-month period of April 2022 to March 2023. Letters to safeguarding partnerships regarding outcome and quality of LCSPRs were not analysed for this report.

2. National reviews and thematic analysis commissioned by the Child Safeguarding Practice Review Panel during 2022/2023

- Child Protection in England

  National child safeguarding practice review into the murders of Arthur Labinjo-Hughes and Star Hobson (CSPRP, 2022c).

- Multi-agency safeguarding and domestic abuse

  Child Safeguarding Practice Review Panel paper setting out key findings from reviews where domestic abuse featured (CSPRP, 2022f).

- Bruising in non-mobile infants

  Child Safeguarding Practice Review Panel paper about the management of bruising to children (CSPRP, 2022b).

- Safeguarding children with disabilities in residential settings

  National safeguarding practice review into safeguarding children with disabilities and complex needs in residential settings. The phase 1 report was published in October 2022 and examined allegations of abuse and neglect of children living in three private residential settings located in Doncaster. The phase 2 report was published in April 2023 and sets out recommendations to improve the safety, support, and outcomes for children with disabilities and complex health needs living in residential settings (CSPRP, 2022g; CSPRP, 2023b).

Foreword

Safeguarding children is a critical public service. It is unremittingly complex, difficult and reliant on a wide range of services working together. It requires professionals to work with immense skill to find out and respond sensitively to what is happening to children in the private realm of family life and in their communities. We expect them to 'think the best of people and the worst' (Dickens et al., 2023a, p. 6).

Working with risk and uncertainty is in the DNA of safeguarding practice. Leaders have the unambiguous responsibility to foster and sustain the best possible environment to support safeguarding practitioners to undertake the demanding work of protecting children.

This annual report from the Child Safeguarding Practice Review Panel serves as a barometer of the health of the national safeguarding system, highlighting both strengths and areas for improvement in multi-agency practice. It provides insights into patterns in English safeguarding practice, examining learning from incidents where children have died or suffered serious harm due to abuse or neglect. The children at the heart of this report endured shocking, almost indescribable, violence and maltreatment. We must never become inured or habituated to this. What happened to these children cannot be undone, but what we must do is assess how well agencies responded to their needs.

Analysis of evidence from national and local reviews in this report sheds light on the lives of children and on safeguarding practice. It is, for example, striking that over half of the reviews observed that a child had experienced neglect and that that a high proportion of school age children who died or were seriously harmed were either not in school (11%) or reported to be regularly absent (29%). That 21% of children were reported to have one or more mental health conditions similarly underlines the imperative of health, care, policing, and other services working seamlessly together. Some types of abuse, such as sexual exploitation, and the abuse of children from specific communities and ethnic groups are less regularly profiled in reviews than might be expected. The reasons for this should be explored in more detail.

We undertook 2 major national reviews in 2022/23. The first, Child Protection in England report (CSPRP, 2022c) concluded that multi-agency arrangements continue to be more fragmented and fractured than they should be. The second – published in 2 parts – Safeguarding children with disabilities and complex health needs in residential settings health needs in residential settings (CSPRP, 2022g; and 2023b) brought into sharp and disturbing relief how this group of children are often rendered invisible and 'forgotten'. We welcome the constructive response to our recommendations from government, safeguarding partners and other stakeholders. Those commitments must now be translated into securing the system and practice improvements that are required. Funding,

recruitment, and retention pressures have had a discernible impact on the delivery of the best safeguarding practice to children and families. Despite these system stressors, practitioners and leaders are bringing remarkable creativity and resourcefulness to helping children and families. The past two years have been characterised by rich policy discussions and the initiation of a swathe of important safeguarding reforms. National and local leaders must now, with necessary resources, build on this momentum and cross-government commitment to realise the ambitions of these reforms.

Recently I was asked whether there are too many reviews. It is a cogent and important question to which there is no simple answer. The quality of learning emanating from reviews has undoubtedly improved but the degree to which this has resulted in discernible changes in practice is less evident. Dickens et al's suggestion that 'there is a large dose of magical thinking in repeated calls' to learn lessons and prevent child deaths happening again warrants consideration (Dickens et al., 2023b, p. 16). England now has a strong learning system. We should concentrate attention on deeper questions about why practitioners and managers acted in the way that they did to create the optimum multi agency practice environments to safeguard children and enable them to thrive.

The wider context of an expected general election this year makes this is a good moment to take stock of how we can best continue to improve the English safeguarding system, building on its many strengths whilst recognising where and why it does not always work in children's best interests.

Annie Hudson
Chair
Child Safeguarding Practice Review Panel

Executive Summary

The Child Safeguarding Practice Review Panel's fourth annual report covers our work from 1 January 2022 to 31 March 2023, bringing it in line with financial year reporting. Its aim is to disseminate evidence and learning originating from our unique national oversight of rapid reviews and Local Child Safeguarding Practice Reviews (LCSPRs) and of undertaking our own reviews about issues of national significance. This report presents our collective understanding of how best we can help keep children safe through effective multi-agency practice.

Our updated analysis shows that the practice themes from last year's report remain relevant, despite some good practice being identified. We have looked at how learning can inform practice of senior leaders and middle managers as well as for those involved in direct practice. We have also considered the role of strategic leaders and the organisational conditions that will best enable and sustain embedding recommendations that will drive long-term change. We set out key findings, although more detailed messages, learning points and reflective questions can be found in the report.

The evidence base

The findings presented in this report are based on:

- serious incident notifications (SINs) during the 15-month period of January 2022 to March 2023 with a focus on the 12-month period of April 2022 to March 2023
- rapid reviews with incidents that occurred during the 12-month period from April 2022 to March 2023
- a sample of LCSPRs produced during the 15-month period of January 2022 to March 2023
- letters to safeguarding partnerships from the Panel used to assess the quality of rapid reviews cover incidents that occurred during the 12-month period of April 2022 to March 2023

We also draw on evidence in the 2 national reviews and 2 thematic reviews we published in 2022 and 2023 to help explore themes emerging from the SIN, rapid review and LCSPR data:

- Child Protection in England

  National child safeguarding practice review into the murders of Arthur Labinjo-Hughes and Star Hobson.

- Multi-agency safeguarding and domestic abuse

  Child Safeguarding Practice Review Panel paper setting out key findings from reviews where domestic abuse featured.

- Bruising in non-mobile infants

  Child Safeguarding Practice Review Panel paper about the management of bruising to children.

- Safeguarding children with disabilities in residential settings

  National safeguarding practice review into safeguarding children with disabilities and complex needs in residential settings. The phase 1 report examined allegations of abuse and neglect of children living in three private residential settings located in Doncaster. The phase 2 report sets out recommendations to improve the safety, support, and outcomes for children with disabilities and complex health needs living in residential settings.

The current operating context, change and challenges

We consider how changes in the conditions of practice, in policy frameworks and in some aspects of children's lives have affected safeguarding practice. For example, lost education, poor housing, poverty, adverse mental and emotional health can trigger, intensify or be the backdrop to affect a family's ability to cope, which can affect their parenting and heighten risks for children. Feedback from safeguarding partners has highlighted a range of issues which can hinder their capacity to help and protect children. This includes challenges in workforce recruitment and retention, preventative and early help services, and in provision for children with mental health needs.

Perennial practice challenges continue to persist and are not easily solved through policy and procedural changes. Instead, the safeguarding system needs to better understand these issues through pursuing, in greater depth, the 'why' question in learning reviews. A significant number of national policy and practice reviews have been published: revised Working Together to Safeguard Children statutory guidance and a new National Practice Framework for children's social care have also been published. Together these create important opportunities for securing improvements in how agencies work together to protect and help children.

‘A window on the system’ – ‘who’ and ‘what’ is featuring within SINs and rapid reviews

There were 393 SINs and rapid reviews submitted for serious incidents where abuse and/or neglect is known or suspected that occurred between April 2022 and March 2023. Around two-fifths of these due to the death of a child and around three-fifths due to serious harm, which is similar to the 2021 figures. In over three-quarters of cases the family of the child was known to children’s social care either as an open case or previously, and a third of children were either on, or had previously been on, a child protection plan. In addition, nearly a fifth of children were classed as ‘looked after’ either at the time of the incident or previously. We have identified how a range of factors were present in the lives of these children, for example mental health needs, especially among teenagers, ongoing neglect, and absence from school. Other key findings from SINs and rapid reviews include:

- The age distribution within rapid reviews shows a similar pattern to the 2021 report with a predominance of infants under the age of 1 (36%) with a second peak in the 11 to 15 age group (21%).
- In comparison to the 2021 census figures for 0 to 17-year-olds, children from mixed/multiple ethnic groups and Black/African/Caribbean/Black British ethnicities were overrepresented in the rapid reviews. Conversely, children from Asian/Asian British ethnicities or other ethnic groups were underrepresented in the rapid reviews.
- Reasons for death showed some variation by sex, with girls (20%) experiencing higher rates of suicide than boys (6%) and boys showing higher rates of both extrafamilial child-homicide and extrafamilial fatal assaults combined than girls (17% versus 3%).
- Reasons for serious harm also showed some variation by sex, with females (38%) more likely to suffer child sexual abuse than males (8%) while males experienced higher rates of both intrafamilial non-fatal assaults (39% versus 20% for female children) and extrafamilial non-fatal assaults (14% versus 3% for female children).
- Over half of rapid reviews (53%) noted that the child had experienced neglect prior to the incident. This was the same proportion for those incidents where the child had died (53%) or had suffered serious harm (52%).
- Of the 133 children of school age (aged between 4 and 15 years old) and subject to a rapid review for an incident that occurred between April 2022 and March 2023, the majority (64%, n=85) were enrolled at a mainstream school at the time of the incident, with a further 18% (n=24) enrolled either at a special educational needs establishment or in alternative provision.
- Overall, a fifth (21%, n=81) of children who were the subject of a rapid review were reported to have one or more mental health conditions, either diagnosed or undiagnosed.

Quality of reporting and reviews

Most safeguarding partnerships are conducting and submitting their rapid reviews within 15 working days of notification to the Panel. The quality of LCSPRs continues to improve, although further focus is still required to ensure safeguarding partnerships look at the 'why' and have clear recommendations that set out how they will impact practice and how this will be evaluated. There is also still work to be done around the inclusion of key demographic characteristics, although the Panel is pleased to see that the reporting of child ethnicity continues to improve.

- The Panel are encouraged that 78% of rapid reviews had a completion date of within 15 working days of incident notification, and overall, 95% had a completion date within 20 working days.
- We agreed with 89% of the decisions made by safeguarding partnerships as to whether an LCSPR was needed. However, the Panel think that recommendations emerging from LCSPRs may not always be sufficiently clear, robust, or measurable to lead to the changes required to improve practice, thereby better protecting, and supporting children and families.
- While many safeguarding partnerships are including relevant information and learning in rapid reviews and LCSPRs, we do continue to see too much emphasis placed on detailed chronologies that reflect agencies' contacts rather than sufficiently in-depth analysis of what happened and why.
- Most frequently, the Panel has identified insufficient attention being given to a child and families' context, history, and what life has been like for a child. The Panel has also observed that reviews often focus on a specific incident or episode rather than evaluating the impact of family history and experience over time with different agencies.
- We saw that while 95% of rapid reviews recorded the ethnicity of the child at the centre of the rapid review – an increase on previous years – this did not always translate into the review considering its impact on a child's life and on practice.

Practice themes to make a difference

In our 2021 annual report, we highlighted 6 practice themes to make a difference in reducing serious harm and preventing child deaths caused by abuse and neglect. These themes were not new then, and we continue to see them emerging in rapid reviews and LCSPRs analysed for this current annual report. The summary findings below highlight just some of the key issues we observed in reviews, with further detail provided in the main report. For the first time in our annual report, we have specifically highlighted examples of good practice reflected in LCSPRs.

- **Effective leadership and culture supporting critical thinking and professional challenge.** We observe limited commentary and assessment in rapid reviews and LCSPRs about leadership and culture. However, we did see cases where practitioners would have benefited from more time, resources, and training to gain knowledge, skill, or confidence in relation to different aspects of child protection work, and in working in a multi-agency context. We found that earlier intervention by senior or middle managers in complex or long-standing cases might have resolved blockages and facilitated necessary action sooner for children and families. We noted a weak translation of learning into practice, with previously identified learning not always leading to significant changes in practice and approach. Some reviews continued to show a lack of professional challenge between colleagues and between agencies as well as concerns not always being escalated where there was disagreement between agencies. This lack of professional challenge between colleagues and agencies reflects the need for senior leaders to help foster an environment for safe professional challenge within multi-agency child protection work.
- **Giving central consideration to racial, ethnic, and cultural identity and impact on the lived experience of children and families.** Our analysis has shown that race, ethnicity and culture and their importance for understanding the lived experience of children are not always being explored within reviews, although we did see some examples of good practice that demonstrate how some practitioners are making these issues much more central to their work. It is important that the Panel, safeguarding partners and other stakeholders continue to develop and enhance our understanding about the impact of race, racism, ethnicity and culture on both the lives of children and families and how agencies, individually and together, design and deliver services to help and protect children.
- **The importance of a whole family approach to risk assessment and support.** The absence of a whole family approach was evident across many of the reviews with services often focused on one specific family member, most often the mother or the child who was the focus of the review. The vulnerabilities of other family members were not routinely recognised or included in assessments, nor was the impact of these vulnerabilities within the household always considered. ‘Silo’ working in individual agencies at times led to missed opportunities for partnership relationship building and more effective co-ordinated multi-agency responses. Importantly, while the child should be the focus of child protection activity some reviews continued to show that the voices of children themselves were absent from service records.
- **Recognising and responding to the vulnerability of babies**. The most prominent issues that emerged centred on the challenges practitioners face when exploring the vulnerability of babies with parents and wider family, and whether and how they recognise contextual factors, such as parental mental health and trauma, when assessing risk to babies. Challenges in information gathering and sharing was also prevalent, relating to information both within and between agencies. There continues to

be a real need for practitioners to fully consider any potential risk to children from fathers, any new partners of parents, or other adults with close and regular contact with the family, regardless of sex, gender, or sexuality.

- **Domestic abuse and harm to children – working across services.** Limited understanding of domestic abuse among practitioners was notable in reviews, which is affecting their ability to respond in a timely and appropriate way. In cases where parents have co-parenting responsibilities, there tended to be a focus on removing the perpetrator without considering whether this may in some regard be harmful for the children, particularly if the perpetrator may also have a protective role in their care. We saw how opportunities to identify and respond to domestic abuse were sometimes being missed. Limitations in information sharing meant that key agencies were not always aware of domestic abuse within families where they may have had important information to share or a role to play.
- **Keeping a focus on risks outside the family.** We continue to see examples of practitioners focusing on a child's behaviour which challenges rather than seeing this as a potential sign of child exploitation. Focusing on behaviour links closely to previously identified issues around a lack of professional curiosity where services have undertaken assessments with a narrow focus. We also found that the complexity of the transition or crossover between 'exploited-exploiter' and the overlap between victim and perpetrator was not fully recognised, understood or explored by professionals. Practitioners and systems often overlooked the intersectionality of different vulnerabilities experienced by children that increased their potential for exploitation and risk outside the family. There were also missed opportunities to address known risks outside the family on a multi-agency basis, impacting the potential for a more comprehensive response.
- **Six emerging themes are also introduced**. These relate primarily to specific groups of children and families:
  - **Parenting capacity and children with disabilities and health needs**. We observed themes relating to parenting capacity of children with these types of needs, and how these can be compromised by ecological factors. We also saw that, where practitioners' primary focus is on the child's health condition or needs, there is a risk that abuse and neglect go unnoticed**.**
  - **Children with complex mental health needs**. We saw a high prevalence of mental health conditions for teenagers identifying as being LGBTQ+ and those recorded as having a gender identity different to the sex registered at birth or being non-binary. A significant proportion of teenagers with reported mental health conditions were also recorded as experiencing alcohol and/or substance misuse. Suicide was also notable as cause of death for nearly half of those teenagers with mental health conditions who had died, and all of whom were known at the time or previously to Child and Adolescent Mental Health Services.

- **Parental mental health and parenting capacity**. We noted that this could be overlooked, highlighting a need for practitioners to assess parents' awareness of their child's needs. When parental mental health is not fully considered services can also overlook the viability and practicality of parenting arrangements and safety plans. Parents struggling to meet the expectations within plans can then be framed as neglectful rather than as evidence of parents feeling that the demands of them from some agencies are overwhelming.
- **Children not in school**. The latest analysis demonstrated difficulties with a lack of suitable placements and support for children with complex needs and stretched resources within special educational needs services. Case reviews continue to show that too many children spend long periods of time outside of formal education as a result. It is during these periods that some children have died or experience serious harm.
- **Young carers**. We saw how agencies are not always recognising this role for children and the impact this has upon them. These children can be providing crucial support for their parents or other adults, sometimes where they have substance misuse problems, mental health needs or where domestic abuse is present, all which impact on their own capacity to support their children.
- **Working with Gypsy, Roma and Traveller communities**. This theme highlights the importance of exploring the impact of cultural identity and community factors on individual children and families. We saw how cultural barriers could mean that traditions and parenting approaches of Gypsies, Roma and Travellers, as well as those of other ethnic and cultural groups, were not always understood by services and their impact rarely assessed or analysed.

National reviews and thematic analysis

The Panel considered three important cross-cutting themes that have surfaced from our own national and thematic reviews undertaken in 2022 and continue to be observed in rapid review and LCSPR data presented in this annual report. These themes are:

- Knowing what life is like for children, highlighting the centrality of children's voices and experience, and those of their parents, carers, and wider family members, but also the knowledge, skill and confidence required to build a full picture of children's lives to enable the best safeguarding, support and protection.
- Information sharing and seeking which is a perennial issue in child protection and safeguarding work. Issues in this area undermine the ability of practitioners and agencies to have a full and accurate understanding of what is happening in children and families' lives, including any risks of harm.

- Working across agency boundaries, on which information sharing is reliant and which is essential for building holistic pictures of children's lives.

Foundations' review of safeguarding partnerships' annual reports

Under Working Together to Safeguard Children (HM Government, 2023h) safeguarding partners are required to produce yearly reports on the activity they have undertaken in a 12-month period. These should be submitted to the Panel and Foundations, the What Works Centre for Children & Families. Foundations analysed a sample of yearly reports from safeguarding partners for the year 2022/23. Nine reports were analysed in total. There is recognition that, in the context of the revised Working Together, there is a need to review expectations about safeguarding partner yearly reports, including what and how national analysis may need to be undertaken.

- The content and quality of reports continued to vary significantly, despite the Panel recently providing additional guidance to support drafting of yearly reports.
- Most of the reports that were analysed remained descriptive and had little focus on using evidence and data to demonstrate the value or rationale for initiative.
- There continued to be little information regarding the impact that safeguarding activities and interventions are having on the wellbeing and safety of children and families.
- There is a need to support safeguarding partners to produce yearly reports that move beyond describing approaches and activities and place a greater emphasis on the reasons and evidence behind selecting priority areas, the activities carried out and the impact these have.

The Panel at work and future priorities for the work programme

The Panel plays a key role in the English child protection and safeguarding system through:

- its role in 'system oversight' of national and local reviews and how effectively it is operating
- in 'system learning', by identifying and overseeing the review of serious child safeguarding cases which raise issues that are complex or of national importance
- in 'system leadership' through identifying improvements to practice and protecting children from harm

Moving forward, the Panel will continue to deliver its core work in oversight of the system, increase the quality and depth of data analysis of rapid reviews and LCSPRs and continue to build on engagement with safeguarding partners to share practice and disseminate learning. Additionally, the Panel:

- have commissioned 2 new national reviews in 2023, one on child sexual abuse in the family environment and one following the death of Baby M
- are undertaking 2 thematic analyses in 2024, one on neglect and the other on race, culture, and racism, to support the tackling of perennial issues
- will strengthen its relationships with safeguarding partners to maximise the impact of learning from safeguarding reviews, supported by delivery of a new learning support project
- will continue to use its unique position to influence important stakeholders to secure improvements in the multi-agency child protection system including through its contribution to the design and delivery of the Families First for Children pathfinder pilot project

The Panel will also be commissioning work to evaluate its impact.

Conclusion

The report concludes with a series of reflective questions for safeguarding leaders to support them in promoting the very high standards of safeguarding practice and making sure that learning reviews drive longer term change to help children and families. These questions are organised around 6 key strategic themes:

- **Culture**: creating an inclusive culture where professional challenge is promoted.
- **Clear partnership intent:** ensuring clear and balanced partnership working.
- **Strategy to delivery:** ensuring strategy is carried through to frontline practice.
- **Assessing effectiveness:** evaluating impact of the safeguarding system.
- **Getting upstream:** ensuring learning feeds into prevention, early intervention and the commissioning of services.
- **Workforce:** working together effectively across agencies and promoting development.

1. Introduction

1.1 This is the fourth annual report published by the Child Safeguarding Practice Review Panel (hereafter referred to as 'the Panel') since its inception in 2018. We view the annual report as more than just a reporting tool; it is an important mechanism for the Panel to capture and disseminate evidence and learning to those working in the child safeguarding and protection system.

1.2 This report covers the period from January 2022 to March 2023 to begin the alignment of data reporting with the financial, rather than calendar, year to ensure consistency of reporting across the system. This, alongside the establishment of our new partnership with the Vulnerability Knowledge and Practice Programme (VKPP) in 2023 to provide a Data Insights Team to analyse rapid reviews and Local Child Safeguarding Practice Reviews (LCSPRs), has meant that publication of this report is later than we had envisaged.

1.3 Our oversight of national and local reviews provides a unique evidence base and insight into patterns of practice in child safeguarding, enhanced by our national reviews and wider analysis of local reviews. Last year, we highlighted six practice themes which we believe can make a difference to reducing serious harm and preventing child deaths caused by abuse or neglect. The analysis in this report focuses on the extent to which these themes remain salient in practice within more recent rapid reviews and LCSPRs that we are seeing.

1.4 The overarching key finding of this report is that the practice themes do remain relevant, despite some good practice being identified. We have sought to look at how learning can inform practice of senior leaders and middle managers as well as those directly involved in practice.

Six key practice themes to make a difference

1. Effective leadership and culture supporting critical thinking and professional challenge.
2. Giving central consideration to racial, ethnic and cultural identity and impact on the lived experience of children and families.
3. The importance of a whole family approach to risk assessment and support.
4. Recognising and responding to the vulnerability of babies.
5. Domestic abuse and harm to children – working across services.
6. Keeping a focus on risks outside the family.

1.5 In addition, we have considered the role of strategic leaders and the organisational conditions that will best enable and support embedding recommendations that will drive long-term change. These focus on six key areas which we expand on later in the report. The Safeguarding Children's Partnerships self-assessment maturity tool recently developed as part of the facilitator support offer aligns well to these themes and should be of help to safeguarding partnerships in evaluating local partnership practice. Safeguarding leaders may want to attend to five different aspects of multi-agency practice in their areas (see Chapter 10 for further detail):

- **Culture:** creating an inclusive culture where professional challenge is promoted
- **Clear partnership intent:** ensuring clear and balanced partnership working
- **Strategy to delivery:** ensuring strategy is carried through to frontline practice
- **Assessing effectiveness:** evaluating impact of the safeguarding system
- **Getting upstream:** ensuring learning feeds into prevention, early intervention and the commissioning of services
- **Workforce:** working together effectively across agencies and promoting development

1.6 Safeguarding partners must agree and publish plans for an independent person to scrutinise the effectiveness of the arrangements including that local and national child safeguarding practice reviews are analysed, with key learning identified and effectively implemented across the safeguarding system (VKPP, 2022; DfE, 2023).

1.7 Throughout the report, we highlight key messages, learning points and reflective questions for strategic leaders, senior and middle managers and for direct practice as relevant.

Note on language

1.8 We recognise that the language used when referring to children, their families and communities can at times be contested and that preferred terms can develop and change quickly. We thought it would be helpful to clarify some of the terms we have chosen to use within this report.

1.9 We use the term 'children' to refer to both children and young people throughout the report. We use 'children' as this reflects the reality that those under 18 are legally recognised as children, which should always be kept in mind. We do understand and acknowledge that some young people (aged 16 and 17) might prefer not to be referred to as 'children'.

1.10 We use the term ‘serious harm’ when referring to incidents notified to the Panel and the subsequent rapid reviews and LCSPRs. This reflects the higher or more intense levels of harm experienced in these incidents. We use the term ‘significant harm’ when talking more generally about practice and legislation.

1.11 We use the term ‘Black and other minoritised communities’ when referring to communities affected by inequality. We use this term because it is important to recognise that experiences and challenges can vary for individuals with different ethnic or racial heritages. By using this inclusive language, the Panel aims to address the specific issues faced by various communities while emphasising the common goal of promoting equity and addressing disparities.

1.12 We use the term ‘racism’ to encompass all forms of racism, including structural, institutional and systemic racism, that may be discussed or observed within rapid reviews and LCSPRs. We fully recognise the wide range of views that exist when referring to race, ethnicity and culture, and this will be a key focal point for a thematic project we will be undertaking this year.

1.13 As far as possible we have tried to use person-first language. By that we mean language and phrases that place the person before any specific characteristic or feature as we think it is important to recognise the person first and foremost with any relevant descriptors after this, for example referring to ‘children with disabilities’ rather than ‘disabled children’. We use person-first language because this promotes inclusivity and helps combat stigmas or stereotypes associated with certain conditions. Person-centred language is a step towards fostering understanding, dignity and recognition of the full range of an individual’s identity beyond their disability.

1.14 A glossary containing other terms, their definitions and relevant acronyms can be found in Appendix A.

2. Context, change and challenges

2.1 The context in which safeguarding practitioners work shapes their daily interactions with children and families. In this chapter we reflect on how contextual changes across the child safeguarding system are affecting the quality of protection and help afforded to children at risk of harm. Notwithstanding the impact of a range of contextual factors, including heightened risks of extrafamilial harm for some children, there is good evidence to demonstrate the resilience and resourcefulness of the English safeguarding system as it adapts and responds to a changing context and implements improvements that seek to improve children's lives. We are seeing examples of this in LCSPRs in the ways in which safeguarding partnerships are recognising and responding to emerging threats such as extrafamilial harm and in response to legislative changes brought about by the Children and Social Work Act 2017.

2.2 We consider how changes in the conditions of practice and in policy frameworks have affected the safeguarding system as well as discussing the impact of perennial practice problems. Together, these issues provide the contours for the practice of many thousands of safeguarding practitioners and leaders and making sense of them is critical to the system's ability to continuously improve. It is encouraging to see how safeguarding partners are increasingly focussing on how they evaluate their strategies to improve practice, including using multi-agency audits and other forms of scrutiny within peer reviews. As Dickens et al. (2023b, p. 9) have observed, "an individual's practice is shaped by their organisational context and conditions (e.g. workloads, responsibilities, support) and whilst such factors are often mentioned, they are rarely applied rigorously to the analysis of what 'went wrong'.

Conditions in practice

2.3 We argued in Child Protection in England (CSPRP, 2022c) that enabling practitioners to have the very best chance of helping and protecting children involves the analysis and in-depth understanding of the optimum conditions for safeguarding practice decision making. There is evidence in both reviews and feedback from safeguarding partners that a range of factors can hamper the delivery of the very best practice to which everyone aspires. Some factors relate to the needs and lives of children, and some are linked to system capacity and resources.

2.4 It is difficult to judge whether the needs of some children and families have become more complex, or whether service capacity and resource issues has meant that their needs have become more complex to address. However, lost education, adverse emotional and mental health, poverty, poor housing, and social isolation can trigger,

intensify or be the backdrop to a family's ability to cope, which can affect their parenting and heighten risks to children. For example, persistent school absence has been rising nationally (from 12% in the autumn term of 2016-17 to 25% in the same period for 2022/23). There are now over 131,000 children recorded as living in temporary housing (as at 31 March 2023) and 1.6 million children aged under 16 living in absolute low income families in England during 2022/23 (please see Appendix A – Glossary for definition of absolute low income).

2.5 There is evidence too that different groups of children have differential experiences of the safeguarding system. For example, children with white and mixed or multiple ethnic heritages have the highest rates of child protection plans and are the most likely to be looked after a year after referral (Ahmed et al., 2022). Some children are also forgotten and sidelined in public and professional discourse, as we saw in our review of what happened to children with disabilities and complex health needs placed in provision in Doncaster run by the Hesley group. That review highlighted powerfully how this group of children often have no power and voice in what happens to them; this will be intensified when they are living in residential settings, often far away from their families.

2.6 How these factors translate and impact on safeguarding practice is not clear and a range of factors will influence 'demand' (see Bywaters et al., 2020 for a discussion of the relationship between inequality and child protection practice). It is noteworthy that there has been a steady increase in children in need numbers and children in care since 2020, recognising this can be attributed in part to children being in care longer and increases in the number of children of unaccompanied asylum seekers requiring support. For example, there were 225,400 child protection Section (47) enquiries in the year ending March 2023, which is the highest figure since the series started in 2013. Overall, 28% of these enquiries (n=63,870) resulted in a child protection plan which is a reduction on the previous year where 30% of enquiries resulted in a Child protection plan (CPP).

2.7 This may indicate that too many children and families may be being brought into the child protection system unnecessarily (MacAlister, 2022). Good multi-agency decision-making and expertise is required to enable the system to be effective in identifying the children who need safeguarding and protection. Local areas will want to scrutinise their processes to ensure they are identifying the right children.

2.8 Importantly there are new and emerging threats to children because of developments in technology, social media and potentially in artificial intelligence, too. All agencies, including police and children's services, are feeling the pressure of these in their work, often struggling to keep pace with developments beyond their control, and with particular implications for children who are at risk of criminal and sexual exploitation.

2.9 Discussions with safeguarding partners have highlighted 4 critical issues that hinder their capacity to help and protect children. Firstly, there has been a discernible increase in the numbers of children suffering mental and emotional health challenge, particularly since the COVID-19 pandemic. This in turn has undermined the capacity of a range of services to assess, help and protect children. There is evidence in some areas that significant waiting times for assessment and diagnosis, particularly for neurodiverse conditions (such as ADHD and autism) and for speech and language support has meant that children's needs are not being addressed in a timely way (NHS Confederation, 2022; NHS Providers, 2023).

2.10 A considerable number of reviews highlighted that health and local authority commissioning systems continue to be poorly aligned in many areas of the country. There needs to be more 'jointness' in the commissioning, planning, and delivery of services. Without this shift in approach, children with disabilities and who have complex health needs, and children who self-harm and have fragile mental health will be unable to access the quality of support they need from a range of services. The issue of alignment was a key theme in our Safeguarding children with disabilities and complex health needs in residential settings review, with concerns about child and adolescent mental health services (CAMHS) tier 4 placements and Deprivation of Liberty Orders persisting more generally (Care Inspectorate, 2022; Care Quality Commission, 2023; CSPRP, 2022g; Roe, 2023). This emphasises that there must be greater collective will to think and act together, both nationally and locally (CSPRP, 2023b).

2.11 Secondly, reports by the Competition and Markets Authority (2022) and The Independent Review of Children's Social Care (The Care Review) (MacAlister, 2022) have evidenced how placement sufficiency for children looked after by local authorities is an acute problem. It is a theme which recurs in many of the reviews, particularly around adolescents with complex needs. Too many children who are looked after are living at considerable distances from their family and community networks. They are in settings where the quality of care cannot be effectively monitored and is not of the consistently high standards to which all children should have an inalienable right. These were major themes in our Safeguarding children with disabilities and complex health needs in residential settings review (CSPRP, 2022g; CSPRP, 2023b). We know that these issues are complex and support the ambition of all stakeholders, including government, to tackle these.

2.12 Thirdly, major challenges in workforce recruitment and retention, most obviously in children's social care and health visiting, impact on the quality of practice (MacAlister, 2022). During 2022, there was a decline in children and family social workers (Department for Education, 2023f). This is likely to have played a role in the rise of job vacancies, the employment of agency workers, and the average caseload. There is a similar picture within policing where a significant number of experienced officers are departing and the recent uplift has led to a rise in less experienced officers on the

ground, potentially affecting the overall competence of forces (HMICFRS, 2023b). In the recent State of Health Visiting report (Institute of Health Visiting, 2023), there is evidence of a year-on-year decline in the number of health visitors. Together with an increase in population numbers and level of vulnerability, the decline in workforce numbers places significant pressures on health visiting services in meeting the scale of need. Workforce challenges also significantly impacted on practice in the Hesley homes, particularly turnover of staff and appropriate staff ratios (CSPRP, 2022g).

2.13 Workforce churn and over reliance on agency staff results in missed opportunities for practitioners to build meaningful relationships over time with families. Children (and families) will only talk about what is happening to them when they feel secure that they can trust practitioners to act in their best interests; telling their 'story' repeatedly to different professionals can deter them from talking to and trusting professionals. Workforce instability is also likely to exacerbate an 'episodic' and 'threshold' driven style of practice leaving professionals being less able to understand a family's history, their strengths/protective factors and whether there is a risk of harm.

2.14 Fourthly, prevention and early help support to families are, in many areas, under pressure as a result of reduced resources over several years (MacAlister, 2022; Action for Children, 2022). This has undermined the ability of services to provide help at an earlier stage and before problems become more acute. We welcome the emphasis in the Children's social care: stable homes, built on love reforms on trialling and testing new ways of delivering preventative services (Department for Education, 2023e). These need to be properly resourced and a multi-agency endeavour, bringing together the resources and expertise of different services to work coherently with children and families. Too many reviews speak of the disconnect in the way that services work together, reducing their ability to make a meaningful difference to children and families.

Securing momentum and managing change in an evolving policy landscape

2.15 The past couple of years have been a busy period in terms of policy development and change, creating important opportunities for tackling some deeply entrenched problems in the way in which agencies help and protect children and families. The scale of change requires careful navigation, resources, and effective multi-agency leadership so that policy intentions are translated into positive changes for children.

2.16 Important policy and practice reviews include The Care Review (MacAlister, 2022), the Panel's Child Protection in England (CSPRP, 2022c) and Safeguarding children with disabilities and complex health needs in residential settings (Parts 1 and 2) (CSPRP, 2022g; CSPRP, 2023b) as well as the report of the Independent Inquiry into Child

Sexual Abuse (IICSA, 2022). The government's response to the first 2 of these reports was published in Children's social care: stable homes, built on love (Department for Education, 2023e). The new national pathfinder programme is now trialling and evaluating novel approaches to family help and child protection. Additionally, a revised Working together to safeguard children (HM Government, 2023) a new Children's social care: national framework (Department for Education, 2023d), a kinship strategy (Department for Education, 2023a) and a data strategy (Department for Education, 2023c) have all been published.

2.17 There has also been consultation on a new mandatory reporting duty. Most recently, government published its response to the Panel's national review on Safeguarding children with disabilities and complex health needs in residential settings (Department for Education, 2023j). Finally, there have been major changes in the organisation and governance of health services, including the establishment of integrated care boards. These new policy frameworks have important implications for safeguarding leaders and practitioners.

2.18 Firstly, the scale and breadth of these changes requires skilful 'tailoring' by safeguarding partners and others, including government, to ensure that different elements of these policy changes are carefully pieced together creating a coherent and meaningful narrative about what they mean for day-to-day practice. For example, it is crucial that the welcomed emphasis on a better family help offer (including section 17 guidance) is mirrored by investment in a strong and effective multi agency child protection function. They are different sides of the same coin (MacAlister, 2022; HM Government, 2023). Leaders will therefore need to connect the different reforms to maximise impact. For example, government's response to our national review asks local leaders to commission and deliver more localised solutions to the care, education and protection needs of these children (Department for Education, 2023j). This will require leaders to think about how new safeguarding partner governance arrangements might need to know about and oversee what is happening to this group of children.

2.19 Secondly, practitioners must have time, space, and training to absorb and integrate these changes into their practice. The emphasis in the revised Working Together on the importance of multi-agency leadership is crucial. Leaders must be accountable not only to their own agency but also for the quality of practice across the local safeguarding system. Working Together includes new principles for working with parents and carers; practitioners and supervisors will need to translate these principles and think through what this means for different practice scenarios. For example, how should these principles be applied when working with a parent who repeatedly misuses alcohol without compromising their ability to take decisive action if a child is at risk of harm (HM Government, 2023)?

2.20 Thirdly, national, and local leaders need to be bold and courageous to secure improvements, following the evidence about what works best to support change, including on a national scale where this is indicated. The national pathfinder programme provides a unique opportunity to test out different approaches to providing help and protection to children. It is especially vital, in the context of a likely general election over the next 12 months, that there is strong and continued momentum in the delivery of required policy and practice changes.

2.21 The pathfinder programme provides unique opportunities for bringing agencies and professionals much closer together, including in multi-agency child protection teams. In Child Protection in England (CSPRP, 2022c) the Panel suggested that too often a fragmentation of safeguarding responsibilities and decision making undermines the effectiveness of safeguarding practitioners to help and protect children. We have continued to see many reviews where there are fault lines in the way that the safeguarding system is designed, for example, with agencies working in silo, information not being brought together in a timely way, and assessments being undertaken in parallel. As a result, professionals do not always have a clear and full picture of what is happening in a child's life and necessary decisions are not being taken at the right time. We think that these issues can be best tackled by establishing multi-agency child protection teams. We acknowledge the view of some that Panel's proposals for reform might be seen as being "cast in its own image" (Dickens et al., 2023b, p. 9) and that organisational change can be very distracting. Nevertheless, evidence reviewed by the Panel routinely highlights that, despite considerable resource and expertise in the English safeguarding system, our operating models do not use this in the best and most effective ways.

Tackling perennial practice challenges

2.22 Child Protection in England (CSPRP, 2022c) highlighted the seeming intractability of some systemic issues within safeguarding practice, including those about information sharing and accepting too readily what a parent may say. These perennial issues will not be easily resolved through policy and procedural changes, or better training and supervision as safeguarding children is extremely complex. It involves instead working with the uncertainty and fluidity of human lives, of managing risk proportionally, and of accepting the intrinsic fallibility of human beings (families, practitioners, and leaders). We could better concentrate our efforts on making sense of why certain practice issues repeatedly surface. It is positive that the Panel sees increasing evidence that some safeguarding partners are pursuing the 'why' question in their learning reviews to good effect.

2.23 The apparent lack of 'professional curiosity' is one of the perennial practice themes that is routinely articulated in many rapid reviews and LCSPRs, but it is a term that is too often used without a deeper analysis of what it might mean. As Dickens et al. (2023a) concluded in their important piece 'Re-envisioning professional curiosity' there is often a reluctance to analyse 'why' practitioners might struggle to be curious and enquire beyond what is presented to them to know better what is really happening in families' lives. Dickens and colleagues (2023a, p. 8) suggest that we should instead be "locating curiosity and challenge within wider frames of communication and courage" making sense of how the context enables or disempowers practitioners from exploring difficult issues with children and their parents and carers.

2.24 We strongly believe the nature of the work means that practitioners must feel safe to express concerns, talk about difficult issues and have access to the very highest support and supervision. Without these conditions in place, the enquiring approach that is integral to good safeguarding practice will be so much more difficult to achieve. It is vital therefore that safeguarding leaders give attention together to the decision-making environment and whether the conditions for taking high-risk decisions are the best that they can be. This involves, among other things, looking at how best to deal with 'noise' (the excessive variation in judgements that should be the same or similar, Kahneman et al., 2021) and 'bias' (when beliefs and assumptions cause decisions to go systematically wrong in a predictable way). Noise and bias will inhibit communication across services, may prevent practitioners from seeing and acting in response to a worrying bit of information and frame how a child and their family is seen and understood.

2.25 In Child Protection in England (CSPRP, 2022c) we evidenced how practice assumptions about a family, once made, were not revised, with significant consequences for the decisions that were subsequently made about Arthur and Star respectively. Our review on Helsey provision highlighted that there was not sufficient curiosity of what was happening to children with communication difficulties and who were far from home (CSPRP, 2022g). Similarly there is evidence that biases about Black children can lead to them being 'adultified' so that they are rendered less vulnerable or in need of early help than their white counterparts (Davis, 2022). The new national pathfinder programme will be able to identify both the benefits and disbenefits of multi-agency child protection teams and whether they support enhanced practice by bringing together the collective expertise, knowledge, and capabilities of different professionals.

2.26 The quality of learning has been immeasurably enhanced across the country. We look forward in 2024 to working with safeguarding partners, Research in Practice, the University of East Anglia and VKPP on our new learning support project to progress collective knowledge about what makes for a learning review that leads to a sustainable difference to practice with children and families. Dickens et al. (2023a, p 8)

suggest that there needs to be more explicit recognition of tensions between the different functions of reviews and that there needs to be greater attention to the "actions and 'in the moment' reasoning of practitioners" and on how local agencies have responded to reviews. This important evaluation work needs to be done. The Panel will commission work in 2024 to evaluate how well the Panel has enabled changes in and had an impact on safeguarding practice.

2.27 The remainder of this report analyses the Panel's evidence about the health of the English safeguarding system through the very many learning reviews being undertaken by safeguarding partnerships across the country. It demonstrates the determination to learn from serious incidents, keeping the interests and wellbeing of children front and centre. The context is challenging and the work always demanding; what is clear is that there is undoubted commitment to improve continuously. We hope that the analysis and questions posed in this report will prompt all those with responsibilities for protecting children to reflect on how they create the very best conditions for safeguarding practice.

3. A window on the system

3.1 This section aims to provide an insight into the incidents and challenges faced by safeguarding partners by sharing the unique information the Panel has access to through its oversight of serious safeguarding incidents and rapid reviews.

3.2 Under 16C(1) of the Children Act 2004 (as amended by the Children and Social Work Act 2017), a local authority in England must notify the Child Safeguarding Practice Review Panel if it knows or suspects that a child has been abused or neglected and serious harm or death has occurred. This initial notification is known as a serious incident notification (SIN). Following the SIN, the safeguarding partnership for that area must carry out a rapid review to establish if there is any immediate action needed to ensure a child's safety and if there is any practice learning.

3.3 The first section of this chapter examines the data from those submitted SINs that progressed to a rapid review based on the date of the incident. As this is the first annual report to be based on financial year (April to March), the SIN data will present figures covering both a 15-month period of 1 January 2022 and 31 March 2023 and the 12-month financial year of 1 April 2022 to 31 March 2023. We have included in this section analysis by region for the first time and intend to build on this in future reports.

3.4 Analysis based on the information from rapid reviews which is presented later in this chapter is also based on incident date and covers the 12-month period of April 2022 to March 2023. These sections contain most of the case analysis and present findings on demographics of the child, types of incidents, needs of the child and parent and risk factors where these were reported within the reviews.

3.5 It should be noted that the numbers of incidents reported for this period may be liable to change in future reports due to the late identification or reporting of incidents.

3.6 An incident may involve more than one child. In cases where more than one child is involved, the child identified in the SIN as the primary child involved in the incident and is the focus of the rapid review is classed as the 'index child'. In instances where this is unclear, we have followed set criteria to identify the index child and subsequent order of input. Following these criteria, the index child would be identified as the child who has suffered the most obvious serious harm or death, or the eldest child involved in the incident as it could be assumed that they would have suffered longest in cases of ongoing neglect and abuse.

3.7 There may be a small number of reviews where it is found that abuse or neglect was not a cause of, or a contributory factor to, the death or serious harm of a child. The Panel recognises that sometimes this can only be established after conducting rapid reviews. The Panel would encourage local authorities to continue to submit these rapid reviews, particularly where there have been previous concerns about abuse or neglect.

Key findings from SINS and rapid reviews

- The breakdown of the categories of death and serious harm reported in the SINs is roughly equivalent to that reported in 2021.
- The age distribution within rapid reviews shows a similar bi-modal pattern to the 2021 report with a predominance of infants under the age of 1 (36%) with a second peak in the 11 to 15 age group (21%).
- In comparison to the 2021 census figures for 0 to 17-year-olds, children with mixed/multiple ethnic heritages and Black/African/Caribbean/Black British heritages were overrepresented within the rapid reviews. Conversely, children with Asian/ Asian British heritages or other ethnic heritages were underrepresented within the rapid reviews.
- Reasons for death showed some variation by sex, with females (20%) experiencing higher rates of suicide than males (6%) and males showing higher rates of both extrafamilial child-homicide and extrafamilial fatal assaults combined (17% versus 3% for females).
- Reasons for serious harm also showed some variation by gender, with females (38%) more likely to suffer child sexual abuse than males (8%) while males experienced higher rates of both intrafamilial non-fatal assaults (39% versus 20% for female children) and extrafamilial non-fatal assaults (14% versus 3% for female children).
- Over half of rapid reviews (53%) noted that the child had experienced neglect prior to the incident. This was the same proportion for those incidents where the child had died (53%) or had suffered serious harm (52%).
- Most families of children who died or suffered serious harm were either open to children's social care at the time of incident (35%) or had previously been known to children's social care (42%). Overall, 10% (n=38) of children were on a child protection plan at the time of the incident and a further 23% (n=90) had previously been on a child protection plan.

Serious incident notifications

3.8 The Panel received notification of 483 serious incidents which occurred between January 2022 and March 2023. Using the mid-year population estimates for England for children aged under 18 (as produced by the Office for National Statistics), this suggests that 4 SINs were submitted per 100,000 child population. Of those 483 notifications, 190 (39%) were in relation to child deaths and 268 (55%) related to serious harm, as shown in Figure 1. In addition, 25 (5%) of notifications were for 'other' issues, for example where the child committed a crime, or it concerned the death or harm of a child looked after in a residential setting. In some cases, 'other' has been recorded on the SIN where serious harm or death is yet to be established.

3.9 During the 12-month period of April 2022 to March 2023, the Panel received notification of 393 serious incidents, of which 146 (37%) were in relation to child deaths and 227 (58%) were related to serious harm, as shown in Figure 1. In addition, 20 (5%) notifications were for other issues.

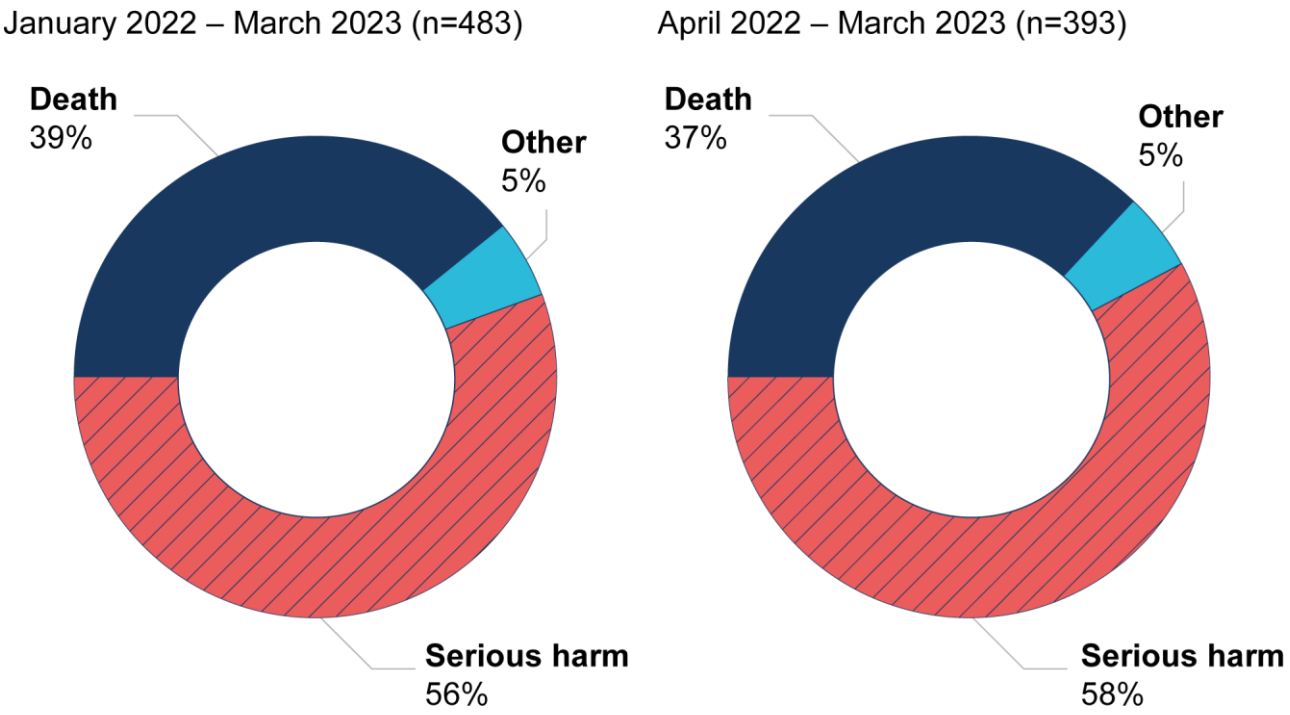

Figure 1. Proportion of serious incident notifications by reason for incidents occurring between January 22 to March 23 and April 22 to March 23

3.10 Figure 2 shows the number of SINs submitted by month of incident, broken down by reason. The number of incidents varied between a minimum of 22 in February 2022 to a maximum of 45 in December 2022, with an average of 32 a month across the 15-month period. Although overall the proportion of serious harm incidents as reported in the SINs was 56%, this ranged from a minimum of 41% of incidents in February 2022 to a maximum of 71% in September 2022.

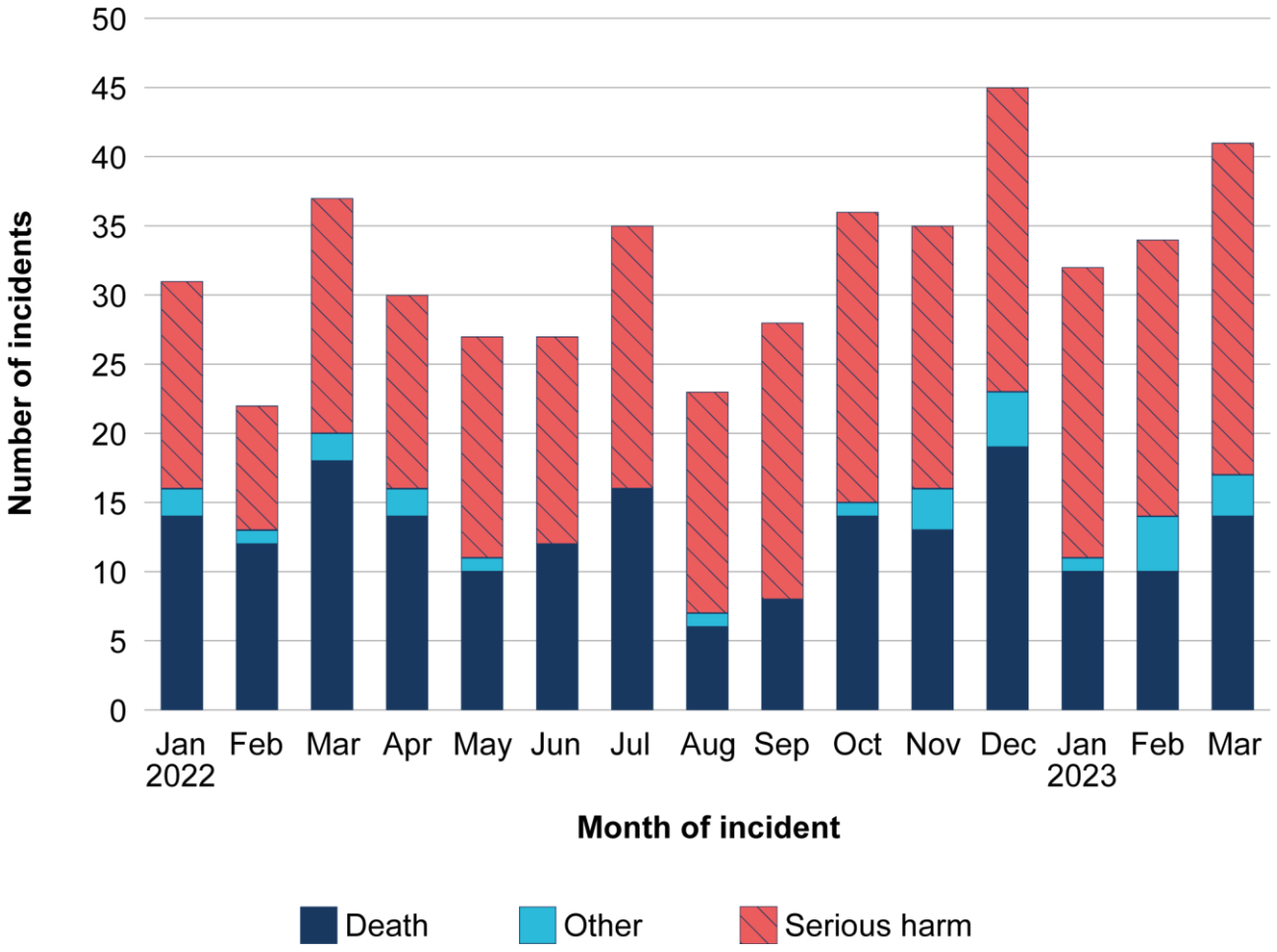

Figure 2. Number of serious incident notification by reason and month of incident, January 22 to March 23

3.11 Local authorities are asked to raise one notification per incident, even if more than one child is affected. During the period of January 2022 to March 2023, 89 incidents involved more than one child. During the 12-month period of April 2022 to March 2023 this was 79 incidents. Overall, 636 children were reported as being involved in serious incidents occurring between January 2022 to March 2023, and 529 children for the period of April 2022 to March 2023.

3.12 Figure 3 shows the number of SINs submitted per 100,000 child population by region for the 15-month period of January 2022 to March 2023. These rates are not a comment on the practice of the regions, however it is interesting to see that there is a group of 5 regions (South West, North East, West Midlands, London and Yorkshire & the Humber) each submitting between 4 and 5 SINs per 100,000 child population during the period, followed by a second group of three regions (South East, East Midlands, and East of England) who each submitted between 2 and 3 SINs per 100,000 population. The North West region had the highest rate of submissions during this period with 6 per 100,000 child population. Differences in notification

numbers across regions could be indicative of varying socio-economic contexts as well as child population sizes and warrants further analysis.

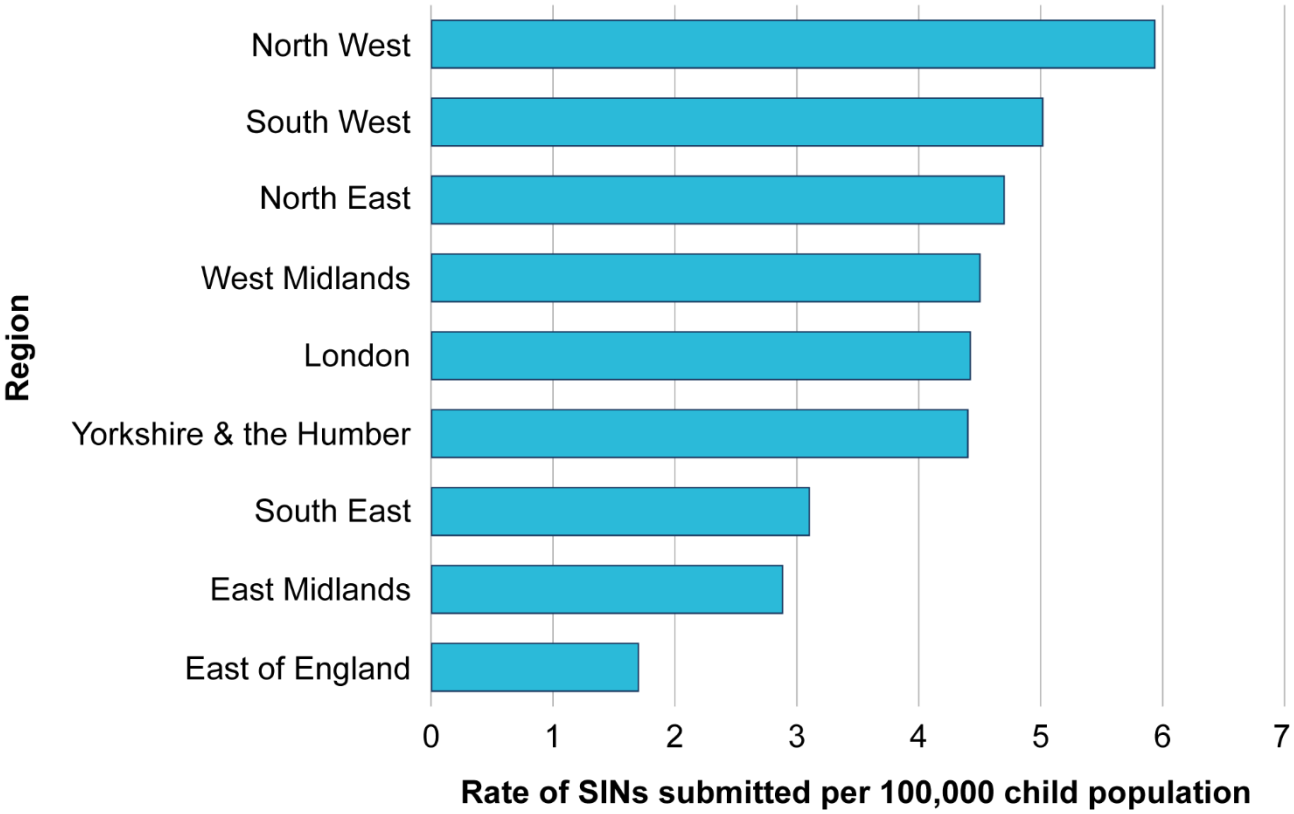

Figure 3. Rate of number of serious incident notifications submitted per 100,000 child population by region, January 2022 to March 2023

Rapid reviews

3.13 The remaining analysis will be based on information from the rapid reviews. The analysis will cover the 12-month period of April 2022 to March 2023 and will focus on the index child identified in the notification.

3.14 In some cases, the reason for notification changed between the SIN and the rapid review occurring, for example if the child died in the time between, or if the reason was no longer determined to be classed as 'other'. This means that among the 393 rapid reviews included in this analysis, there were 156 deaths, 229 serious harm incidents and 8 'other' incidents recorded between April 2022 and March 2023.

Demographic breakdown of incidents

3.15 Figure 4 shows the number of incidents by age group and sex of the child for incidents occurring between April 2022 and March 2023.

- Of the 393 rapid reviews the largest age group represented were children aged under 1 (36%, n=142) followed by those aged 11 to 15 years (21%, n=84).
- In addition, 18% (n=72) of children were aged 16 to 17, 16% (n=63) of children were aged 1 to 5 years old and 8% (n=31) of children were aged 6 to 10 years old.
- There was one rapid review that did not record the age of the child.

3.16 Overall, 54% (n=214) of children were recorded as male and 45% (n=178) were recorded as female. There was one rapid review where the sex of the child was recorded as other.

3.17 In terms of the child's gender, 10 children (3%) were reported in the reviews to have a gender identity different from the sex registered at birth or to be non-binary. This increases to 6% (n=10) when looking at older children, for example those aged 10 years and above (n=167). In addition, 10 children (3%) were recorded in the review to be non-heterosexual, again increasing to 6% (n=10) when looking at children aged 10 years and above (n= 167). Six of the 10 children appeared across both groups. The quality of this data, and data around the characteristics of the child more generally, is discussed in Chapter 4.

3.18 Figure 4 shows the number of incidents by age and sex (male/female) of the child where this is known (n=392).

- The child with a sex of other was aged between 11 to 15 years old.
- In general, male children are slightly younger than female children with 55% (n=117) aged under 5 years old compared to 49% (n=88) of females.
- Conversely, 42% (n=75) of females are aged 11 years plus compared to 38% (n=80) of males.

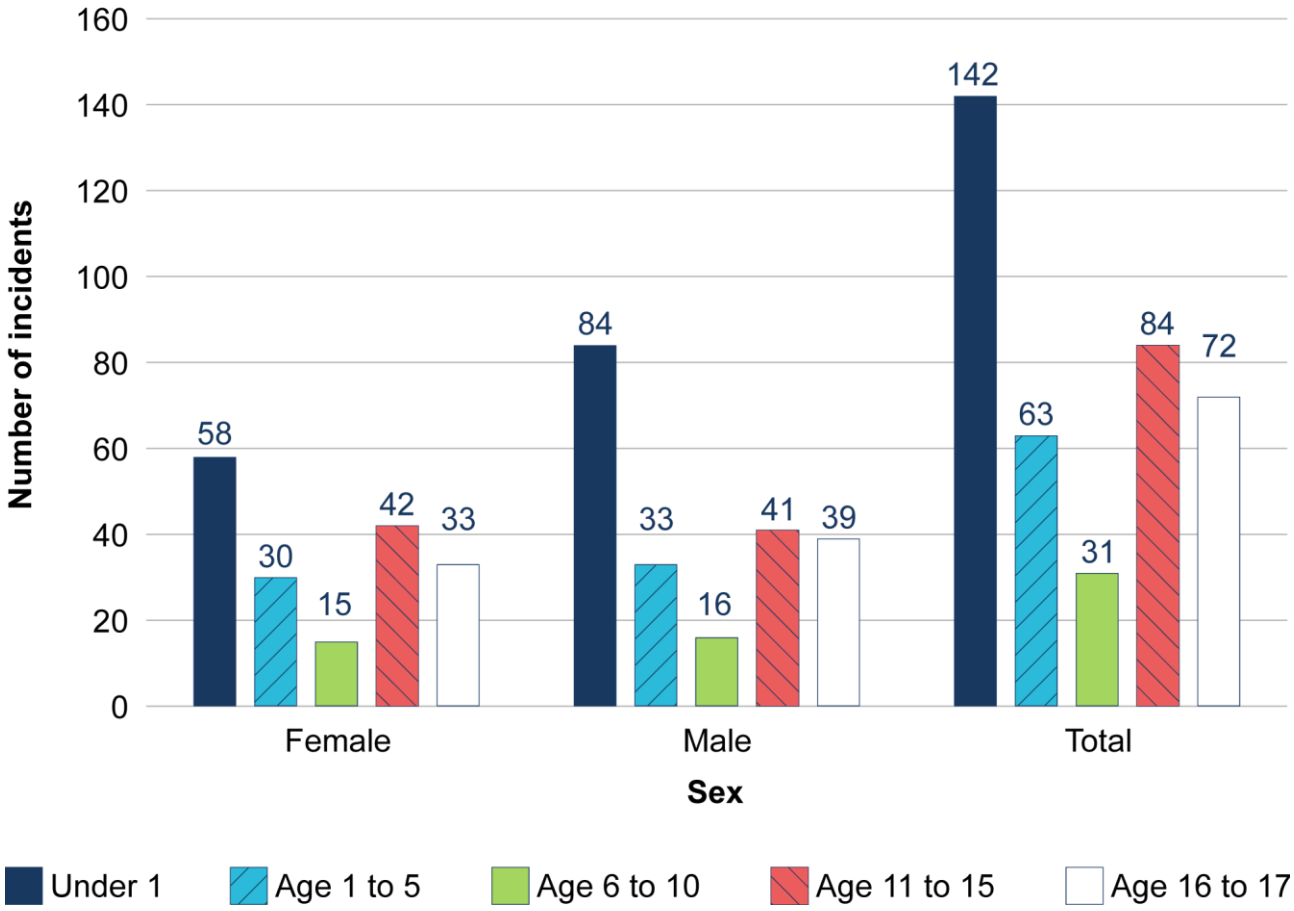

Figure 4. Number of incidents by age group and sex, April 2022 to March 2023

3.19 Overall, the ethnicity of the child was recorded in 95% (n=372) of rapid reviews. Table 1 shows that, where recorded, most children (64%, n=238) were recorded with an ethnicity of white British, with the next largest group being white and Black Caribbean (6%, n=22). Overall, over two-thirds (69%, n=256) of children were recorded as white, 13% (n=50) with mixed/multiple ethnic heritages, followed by 9% (n=34) recorded as Black/African/Caribbean/Black British, 8% (n=28) as Asian/Asian British and 1% (n=4) recorded as other ethnic group.

3.20 In comparison to the 2021 census figures for 0–17-year-olds, Table 1 shows that children from mixed/multiple ethnic groups and Black/African/Caribbean/Black British ethnicities were overrepresented within the rapid reviews. Conversely, children with Asian/Asian British heritages or other ethnic groups were underrepresented within the rapid reviews. It should also be noted that the ethnicities of family members may differ from the child and that this may have an impact on the culture within the family itself. These issues are discussed further in the race, ethnicity, and culture theme in Chapter 5.

Table 1. Ethnicity breakdown of children subject to rapid reviews April 2022 to March 2021 compared to the 2021 census figures for England

	Rapid Reviews		2021 Census
	n	%	%
White	**256**	**68.8%**	**72.5%**
1. White British	238	64.0%	66.9%
2. Irish	2	0.5%	0.3%
3. Gypsy or Irish Traveller	0	0.0%	0.2%
4. Any other white background	16	4.3%	5.1%
Mixed/multiple ethnic groups	**50**	**13.4%**	**6.8%**
5. White and Black Caribbean	22	5.9%	1.9%
6. White and Black African	5	1.3%	1.1%
7. White and Asian	10	2.7%	2.1%
8. Any other mixed/multiple ethnic background	13	3.5%	1.7%
Asian/Asian British	**28**	**7.5%**	**12.3%**
9. Indian	5	1.3%	3.5%
10. Pakistani	13	3.5%	4.5%
11. Bangladeshi	6	1.6%	1.8%
12. Chinese	2	0.5%	0.6%
13. Any other Asian background	2	0.5%	2.0%
Black/African/Caribbean/Black British	**34**	**9.1%**	**5.7%**
14. African	14	3.8%	3.7%
15. Caribbean	7	1.9%	0.8%
16. Any other Black/African/Caribbean background	13	3.5%	1.2%
Other ethnic group	**4**	**1.1%**	**2.7%**
17. Arab	0	0.0%	0.9%
18. Any other ethnic group	4	1.1%	1.8%
Total Known	**372**	**100.0%**	**100.0%**

3.21 The Index of Multiple Deprivation (IMD) decile was established for 284 of the serious incidents occurring between April 2022 and March 2023 based on the postcode of the placement recorded on the SIN. Of these, two-fifths (40%, n=113) of notified serious incidents occurred in the 20% most deprived areas of England. Overall, over three-quarters (76%, n=217) of serious incidents occurred in the 50% most deprived areas in England. However, Figure 5 shows some variation in this when looking at serious incidents by age group and IMD decile. For example, over a fifth (26%, n=25) of serious incidents involving children under one year old occurred in the 10% most deprived areas compared to 15% (n=7) of children aged 1 to 5 years old.

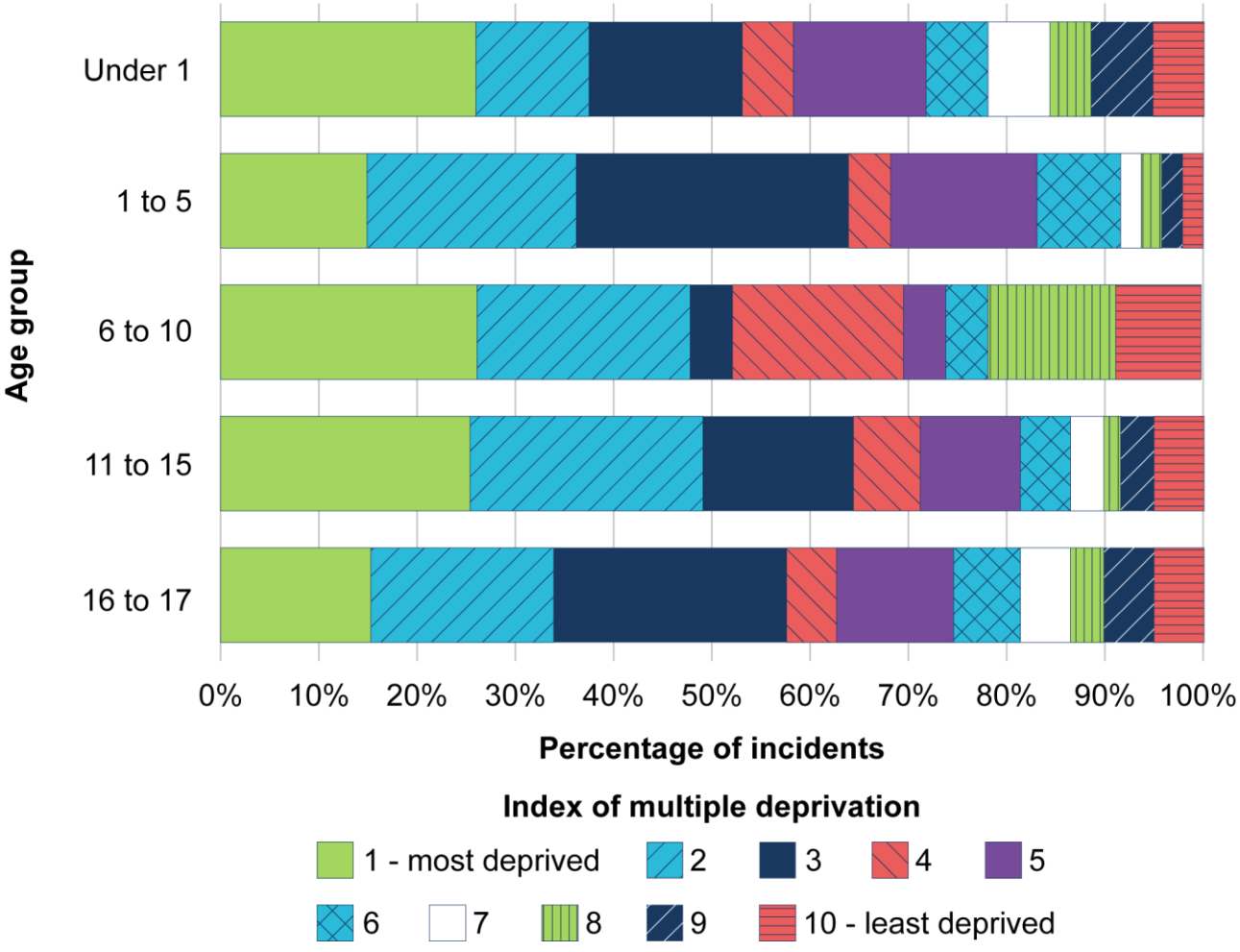

Figure 5. Proportion of incidents by age group and index of multiple deprivation decile, April 2022 to March 2023

Child deaths

3.22 The probable cause of death reported within this section is based on the information presented in the rapid review and what was known at the time of the review and is therefore subjective in interpretation. In some circumstances cause of death may have been suspected but was still waiting to be confirmed and/or changed post-rapid review. Further explanation of the causes of death can be found in Appendix B.

3.23 Of the 156 fatal incidents occurring between April 2022 and March 2023 that were reported to the Panel, 61% (n=95) were for male children and 39% (n=61) were for female children, as shown in Table 2.

Table 2. Number and percentages of fatal incidents by likely cause of death and sex of the child, April 2022 to March 2023

	Female		Male		Total	
Likely cause of death	n	%	n	%	n	%
Unexplained SUDI/SUDC	12	19.7%	21	22.1%	33	21.2%
Suicide	12	19.7%	6	6.3%	18	11.5%
Accident/injury	9	14.8%	8	8.4%	17	10.9%
Child homicide – extrafamilial	2	3.3%	11	11.6%	13	8.3%
Medical	6	9.8%	7	7.4%	13	8.3%
Unclear	4	6.6%	8	8.4%	12	7.7%
Fatal assaults – intrafamilial	4	6.6%	7	7.4%	11	7.1%
Risk taking behaviour	3	4.9%	6	6.3%	9	5.8%
Death from extreme neglect	4	6.6%	4	4.2%	8	5.1%
Overt child homicide by primary caregiver	3	4.9%	4	4.2%	7	4.5%
Covert child homicide by primary caregiver	1	1.6%	5	5.3%	6	3.8%
Fatal assaults – extrafamilial	0	0.0%	5	5.3%	5	3.2%
Severe, persistent child cruelty	1	1.6%	3	3.2%	4	2.6%
Total	**61**	**100.0%**	**95**	**100.0%**	**156**	**100.0%**

3.24 Table 2 shows that over a fifth of rapid reviews relating to fatal incidents (21%, n=33) were for an unexplained sudden death in infancy (SUDI) or a sudden unexplained death in childhood (SUDC). The next largest category of death where abuse and/or neglect was known or suspected was suicide, which accounted for 12% (n=18) of fatal incidents reported in the reviews. However, Table 2 shows that this is greater for female children with 20% (n=12) completing suicide compared with 6% (n=6) of male children. Conversely, child homicide-extrafamilial and fatal assaults-extrafamilial incidents were the likely causes of death in 17% (n=16) of male child deaths compared to 3% (n=2) of female child deaths.

Serious harm

3.25 As with fatal incidents, the cause of harm for serious harm incidents is based on the information reported in the rapid review and is therefore subjective in its interpretation and may have changed since the review took place. Further explanation of the causes of harm can be found in Appendix C.

3.26 Unlike fatal incidents reported, the spilt between serious harm incidents for male and female children (n=229) was more equal with 50% (n=115) relating to female children, 49% (n=113) concerning male children and one (0.4%) where the child was recorded as 'other'.

3.27 Of the 229 serious harm incidents reported in the rapid reviews, the most common cause of harm, as shown in Table 3, was non-fatal assaults – intrafamilial with 29% (n=67) followed by child sexual abuse – intrafamilial (16%, n=36).

Table 3. Number of serious harm incidents by likely cause of death and sex of the child, April 22 to March 23

	Female		Male		Total*	
Likely cause of harm	n	%	n	%	n	%
Non-fatal assaults – intrafamilial	23	20.0%	44	38.9%	67	29.3%
Child sexual abuse – intrafamilial	29	25.2%	7	6.2%	36	15.7%
Non-fatal neglect	13	11.3%	13	11.5%	27	11.8%
Non-fatal assaults – extrafamilial	4	3.5%	16	14.2%	20	8.7%
Severe, persistent child cruelty	12	10.4%	8	7.1%	20	8.7%
Child sexual abuse – extrafamilial	15	13.0%	2	1.8%	17	7.4%
Other non-fatal incident	6	5.2%	8	7.1%	14	6.1%
Accident/injury	1	0.9%	4	3.5%	5	2.2%
Child sexual exploitation	4	3.5%	1	0.9%	5	2.2%
Child criminal exploitation		0.0%	4	3.5%	4	1.7%
Risk taking behaviour		0.0%	3	2.7%	3	1.3%
Self-harm	2	1.7%	1	0.9%	3	1.3%

Likely cause of harm	Female n	Female %	Male n	Male %	Total* n	Total* %
Attempted suicide	2	1.7%		0.0%	2	0.9%
Medical cause	1	0.9%	1	0.9%	2	0.9%
Unclear	1	0.9%	1	0.9%	2	0.9%
Emotional abuse	1	0.9%		0.0%	1	0.4%
Fabricated/induced Illness	1	0.9%		0.0%	1	0.4%
Total	**115**	**100%**	**113**	**100%**	**229**	**100%**

*Includes one child who had their sex recorded as 'other' had a cause of harm of non-fatal neglect

3.28 Serious harm incidents relating to child sexual abuse, both intra and extrafamilial, were more likely to relate to female children with 38% (n=44) of incidents compared to 8% (n=9) cases for males. Conversely, male children were more likely to have non-fatal assaults, intra and extrafamilial, as a cause of harm than female children. These accounted for 53% (n=60) of serious harm incidents for male children compared to 23% (n=27) of incidents for female children.

Involvement with children's social care

3.29 Table 4 outlines the involvement of children's social care (CSC) up to the point of the incident. Overall, 78% (n=305) of families involved in the incidents were known to CSC either as a current open case (35%, n=139) or previously known (42%, n=166). This was slightly higher in cases of death (84%, n=131) than cases of serious harm (72%, n=166). Overall, 11% (n=44) of children were classed as a child in need at the time of the incident and 10% (n=38) were on a child protection plan.

Table 4. Number and proportion of incidents by type of incident and contact with children's social care, April 2022 to March 2023

	Death/ fatal incident n	Death/ fatal incident %	Serious harm n	Serious harm %	Total* n	Total* %
Family known to CSC						
Yes – current open case	58	37.2%	78	34.1%	139	35.4%
Yes – previous known	73	46.8%	88	38.4%	166	42.2%
Total known	131	84.0%	166	72.5%	305	77.6%

	Death/ fatal incident		Serious harm		Total*	
	n	%	n	%	n	%
Child in need (CIN)						
Yes – at time of the incident	18	11.5%	24	10.5%	44	11.2%
Yes – previously	30	19.2%	47	20.5%	81	20.6%
Total CIN status	48	30.8%	71	31.0%	125	31.8%
Child protection plan (CPP)						
Yes – on CPP	16	10.3%	21	9.2%	38	9.7%
Yes – previously on CPP	34	21.8%	53	23.1%	90	22.9%
Total CPP status	50	32.1%	74	32.3%	128	32.6%
Looked after child						
Yes – child in foster care	4	2.6%	20	8.7%	24	6.1%
Yes – child in other residential setting	7	4.5%	8	3.5%	17	4.3%
Yes – child in residential home	4	2.6%	12	5.2%	17	4.3%
Previously looked after	11	7.1%	7	3.1%	18	4.6%
Total looked after status	26	16.7%	47	20.5%	76	19.3%
Child subject to a care order						
Yes – currently subject to care proceedings	1	0.6%	14	6.1%	14	3.6%
Yes – emergency or interim protection order	8	5.1%	15	6.6%	24	6.1%
Yes – permanent care order	2	1.3%	14	6.1%	16	4.1%
Yes – other order	1	0.6%	13	5.7%	14	3.6%
Yes – previously subject to care order	3	1.9%	7	3.1%	10	2.5%
Total care order status	15	9.6%	63	27.5%	78	19.8%
Total Incidents	**156**		**229**		**393**	

* The total includes 8 incidents classed as ‘other’

3.30 Overall, 15% (n=58) of children were recorded as looked after children at the time of the incident, either in foster care (6%, n=24), a residential home (4%, n=17) or in another residential setting (4%, n=17), with a further 5% (n=18) of children previously being looked after. However, the proportion of children recorded as being looked after at the time of the incident was greater for children experiencing serious harm (17%, n=40) than those who died (10%, n=15). Conversely, a greater number of children who died were recorded as being previously looked after (7%, n=11) compared to those who experienced serious harm (3%, n=7).

3.31 There is a similar picture when looking at children who were subject to a care order at the time of the incident. Overall, children experiencing serious harm were more likely to be on a care order or subject to proceedings (24%, n=56) than those who died (8%, n=12).

3.32 These figures show that in a large proportion of incidents reported in the rapid reviews, the child protection system had previously identified the children as vulnerable, yet safeguarding professionals were unable to prevent their death or serious harm. We must, however, be very mindful of hindsight bias. Protecting children is difficult and intrinsically complex, involving a range of different agencies and the need to make high risk decisions about children, frequently at pace and with a partial picture of what is happening. It entails practitioners making finely tuned judgements about what is best for a child, working compassionately with families while using their professional authority confidently so that they take decisive action to protect a child when needed. It is demanding and often distressing work.

3.33 Previous Panel reports have highlighted practice learning that shows systematic weaknesses in risk assessment and decision-making, often due to the way that information is shared and analysed within and between agencies. This continues to be a perennial theme of reviews. Our 2021 Annual Report presented the systems framework used in Child Protection in England (CSPRP, 2022c). Safeguarding partners may find this framework useful to aid their learning from serious incidents and evaluating practice more generally in their area. The framework is set out in Appendix D.

Children's education and mental health needs

3.34 As mentioned in the previous section, 10% (n=15) of child deaths and 17% (n=40) of incidents of serious harm occurred in children who were classed as looked after children at the time of the incident. Of the looked after children, 27% (n=4) completed suicide, and of the children who experienced serious harm, over half (58%, n=23) were a victim of sexual abuse or exploitation. As identified in our 2020 report, this demonstrates the need for practice across safeguarding agencies to take account of contextual risks in the child's life. Practitioners should have an awareness of the

range of factors that may add to risk and the complex interplay between them to help prevent future harm.

3.35 Of the 133 children of school age (aged between 4 and 15 years old) and subject to a rapid review for an incident that occurred between April 2022 and March 2023, the majority (64%, n=85) were enrolled at a mainstream school at the time of the incident, with a further 18% (n=24) enrolled either at a special educational needs establishment or in alternative provision. Overall, there were 15 (11%) children not enrolled at school at the time of the incident with 11 of these reported to be receiving elective home education. Nine children (7%) were recorded as having an unknown education status.

3.36 Of those enrolled in a mainstream school (n=85), 29% (n=25) were reported as having regular absences or low attendance and 2 children (2%) were reported as being temporarily excluded at the time of the incident. The impact of this is considered further in Chapter 6.

3.37 Overall, there were 72 children aged 16 and 17 years old subject to rapid reviews. Of these, nearly a third (31%, n=22) were recorded as not being in education, employment, or training. Of these, 12 (54%) died through extrafamilial homicide or fatal assault (n=5), risk taking behaviour (n=4), or completed suicide (n=3).

Focus on children not enrolled in school

There were 11 children included within the reviews who were recorded as not being enrolled at a school and who were instead receiving elective home education. In addition, there were 4 children recorded as not being enrolled at a school and not receiving elective home education. Of these 15 children, a third (n=5) were known to CSC and were either previously on a CPP (n=4) or on a CPP at the time of the incident (n=1), with one of these children dying from extreme neglect.

Children who are vulnerable or at risk of harm will be at increased risk that not being in school makes them invisible to services and that they may then miss out on the supplementary safeguarding that the school environment provides. This issue was highlighted in our 2021 report which found that where visits were conducted by elective home education practitioners, these often lacked safeguarding considerations around the child's circumstances. Safeguarding referrals should also be considered in cases where the child is not enrolled at school and where they are not being electively home educated.

Good practice suggested in the 2021 report includes having policies and procedures in place to support practitioners in identifying vulnerability from the start of the elective home education process, and ensuring the voice of the child is captured at multiple stages including at the point of decision to home educate and throughout their home education. Our data for the 2022/23 reporting period illustrates that children's voices and perspectives were missing from work with the family for 12 of the 15 children receiving home education.

Of the 22 children aged 16 or 17 years old that were recorded as not in education, employment or training (NEET), half (50%, n=11) had previously been on a CPP and one (5%) was on a CPP at the time of the incident.

Overall, more than half of children classed as NEET (55%, n=12) were recorded as having a victim/perpetrator overlap (where the child is a victim but has also committed a crime or inflicted harm or injury on others) and were known to youth offending services. Nearly a third (32%, n=7) were recorded as having county lines and/or child criminal exploitation as a risk factor. Furthermore, 32% (n=7) of incidents were related to gang and/or youth violence.

Our report looking at criminal exploitation highlighted the importance of relationship-based practice and 'reachable moments' for children who are not within the school system due to exclusion or for older children who are not engaging in education, employment or training. However, this should also be expanded to those children who are enrolled in a mainstream school but are regularly absent or have low attendance as nearly a third (32%, n=10 out of 31) were recorded as being both a victim and perpetrator.

3.38 Overall, a fifth (21%, n=81) of children who were the subject of a rapid review were reported to have one or more mental health conditions, either diagnosed or undiagnosed. These include conditions such as anxiety, depression and suicide ideation. Where a diagnosed mental health condition was identified (n=36), the rapid reviews suggested the child's mental health condition was linked to the incident in 47% (n=17) of cases. Of these 17 cases, 59% (n=10) of children suffered serious harm, and 41% (n=7) died. All but one child who died, completed suicide.

3.39 In addition to this, 16% (n=64) of children were reported to be neurodivergent with conditions such as autism spectrum disorder and ADHD. However, this increases to 30% (n=57) when looking only at children aged over 5 years old (n=187).

Focus on mental health in teenagers

In our 2020 Annual Report (CSPRP, 2021a), a common theme in rapid reviews surrounded the lack of accessible mental health support to address early childhood trauma and reduce risk-taking behaviours. There was evidence that the eligibility criteria for Child and Adolescent Mental Health Services (CAMHS) supports limited flexibility and responsiveness to meet children and young people's mental health needs. Best practice is that CAMHS professionals work closely with other agencies in developing support plans for children, including where direct contact with CAMHS is not deemed appropriate.

During April 2022 to March 2023, 134 of the incidents reported involved teenagers (children aged between 13 and 17 years old), of which over half (51%, n=68) were recorded to have one or more mental health conditions. In 31 cases, these were diagnosed conditions. Overall, 72% (n=49) of those teenagers with recorded mental health conditions were known to CAMHS either as an open case (n=23), previously engaged (n=22), with a referral made (n=3) or on a waiting list (n=1).

Understanding the characteristics of the children impacted by mental health conditions is important for partners to ensure the appropriate service provision to support those children. Of the teenagers where mental health conditions were recorded, nearly two-thirds (63%, n=43) were female, 35% (n=24) male and one recorded as other. As noted previously, 10 children were recorded as having a gender identity different to the sex registered at birth or being non-binary. All these children were aged between 13 and 17 years old and all but one (n=9) were recorded as having mental health conditions. This is a similar picture for teenagers identifying as being LGBTQ+ where 7 out of 8 were recorded as having mental health conditions. In addition, 40% (n=27 out of 68) of teenagers with reported mental health conditions were also recorded as experiencing alcohol and/or substance misuse. These figures suggest that safeguarding practitioners need to be aware of the impact of other risk factors and/or key characteristics which may affect a child's mental health and risk of harm.

Suicide was the cause of death for nearly half of those teenagers with mental health conditions who had died (n=12 out of 25). In fact, only 2 teenagers who completed suicide were not reported in the rapid review to have a mental health condition. In addition, three teenagers died following risk-taking behaviour. Furthermore, there were three teenagers who were subjects of a serious harm rapid review due to self-harm and 2 following surviving a suicide attempt, all 5 of whom were reported to have a mental health condition. It should be noted that all these teenagers were known, either previously or at the time of the incident, to CAMHS.

Although these suicides have been subject to a rapid review due to the link with abuse and/or neglect, the Panel encourages agencies involved in safeguarding to have an awareness of the variety of factors that may add to risk as well as those 'final straw' stresses that may lead to suicide.

Within the rapid reviews for incidents occurring during April 2022 to March 2023 there were 7 instances where the use of deprivation of liberty orders was mentioned in cases involving teenagers. Of these 7 cases, all but one was in relation to female teenagers. Five of these incidents related to serious harm, one related to a death by suicide and one was reported as a safeguarding concern.

A deprivation of liberty order was in place at the time of the incident in only 2 of the cases, both in relation to mental health, with one in place to impose restrictions within a psychiatric unit following detention under the Mental Health Act (1983) and one to facilitate a move of placement due to the escalating risk of self-harm. In 2 cases the child had previously been subject to the order, but it was not in place at the time of the incident. Again, in both cases this was in relation to mental health with one child previously detained under the Mental Health Act (1983) several times and in the other case the order had been in place due to emotional wellbeing, self-harm, and suicide ideation. In 2 cases a deprivation of liberty order had not been in place at the time of the incident but there was misunderstanding amongst agencies that one was in place at the time. In one case this was due to not understanding when the order was to come into place, which was at the 18th birthday and in the other was due to not understanding that the current restrictions placed on the child were already proportionate with the child's disability. In the final case, a deprivation of liberty order was sought after the serious incident.

Parent and carer needs

3.40 Of the 393 cases reported to the Panel for the period April 2022 to March 2023, 13% (n=51) involved young parents aged under 25 years old and 3% (n=13) involved parents who had previously been in the care system and could be classed as care leavers, although this was not always easy to identify from the reviews. This suggests that extra help from services, such as GPs and health visitors, may have been

needed to support the parent, particularly for those parents who were under 18 years old. There were 6 incidents (2%) in the reviews where one or both parents were aged under 18, and of these all but one was recorded as being known to CSC either as an open case at the time of the incident or previously.

3.41 Overall, in 18% (n=71) of cases at least one of the parents/relevant adults was reported to have a disability, whether it be physical, mental-health related, learning or developmental. This was similar across cases where the child died (18%, n=28) or came to serious harm (19%, n=43). In addition, in half (50%, n=197) of cases, at least one of the parents/relevant adults were reported to have a mental health condition, although it was not always clear in the reviews as to whether these conditions were diagnosed or not. Again, this was similar between those incidents where the child died (51%, n=80) and the child experienced serious harm (50%, n=114).

3.42 In total, in 38% (n=151) of incidents at least one of the parents/relevant adults were recorded to have an addiction to or misusing alcohol and/or substances (including prescribed substances). This was slightly higher in incidents where the child died (43%, n=67) than where the child suffered serious harm (36%, n=82). As outlined in Out of routine: a review of sudden unexpected death in infancy (SUDI) in families where the children are considered at risk of significant harm a key risk factor of SUDI is parental use of alcohol and drugs during pregnancy and when co-sleeping. Of the 33 cases of SUDI during April 2022 to March 2023, 26 (79%) involved a parent who had alcohol and/or substance misuse recorded.

3.43 Although it may not always be the same parent/relevant adult with mental health conditions and alcohol and/or substance use, there is a higher proportion of cases where both factors are present. Out of the 197 incidents where the parent/relevant adult was recorded to have a mental health condition, 110 (56%) also recorded a parent/relevant adult who misused alcohol and/or substances.

3.44 In a third (33%, n=128) of incidents, the parent was reported to be a single parent with the other parent being ‘invisible’/absent. This was slightly higher for incidents where the child died (36%, n=56) than where there was serious harm (29%, n=67).

3.45 As set out in Working Together, children and families in need of support from a range of agencies and organisations should be subject to an inter-agency assessment to help provide that co-ordinated support (HM Government, 2023). These early-help assessments would help identify what support is needed to prevent needs escalating.

Risk factors

3.46 In half (50%, n=198) of cases from the period April 2022 to March 2023 where a child died or was seriously harmed, the rapid review reported the presence of domestic abuse within the household. In 10% (n=41) of incidents the reviews identified the presence of any intergenerational abuse within the household. In 57% (n=112) of incidents where domestic abuse was reported and 68% (n=28) of cases that reported intergenerational abuse, the reviews also identified issues with males either within or linked to the family who were hidden or invisible to services. Since the enactment of the Domestic Abuse Act 2021 children are now to be considered victims if they see, hear or experience the effects of domestic abuse. As such, child protection systems need to link safety plans for adults with child protection assessments and responses as we identified in our report looking at the Myth of Invisible Men (CSPRP, 2021b). Domestic abuse is one of the priority areas adopted by Foundations with a focus on evaluating interventions that provide support for children.

3.47 Out of the 393 cases from the period April 2022 to March 2023 where the child died or was seriously harmed, the review identified that the child had also experienced abuse prior to the incident, including sexual abuse (23%, n=91), physical abuse (45%, n=177) and emotional abuse (21%, n=84). In general, the previous abuse reported within the reviews was perpetrated more within the family (intrafamilial) than outside of the family (extrafamilial).

3.48 Furthermore, over half of rapid reviews (53%, n=209) noted that the child had experienced neglect prior to the incident. There were similar proportions reported between incidents where the child died (53%, n=83) and where the child suffered serious harm (52%, n=120).

Focus on neglect

Working Together defines neglect as: "The persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development."

As mentioned previously, neglect was a factor in over half (53%, n=209) of the cases where a child died or was seriously harmed. Of these, 8 children died because of extreme neglect, 5 of whom were known to CSC either as an open case (n=2) or previously (n=3). In addition, there were 27 children who were the subject of the rapid review due to serious harm caused by non-fatal neglect. Of these, over half (52%, n=14) were known to CSC either previously (n=7) or as a current case (n=7).

Where neglect was a risk factor (n=209), in 86% (n=179) of these cases the families were known to CSC either previously (n=93) or as an open case (n=86) at the time of the incident. The families were known to early help services in 35% (n=74) cases and in an additional 10% (n=20) of cases either a referral had been made or the family had refused help).

Poverty can often be a factor in neglect as it can increase stress for parents, especially those who are vulnerable (Joseph Rowntree, 2023). This can be seen when looking at the IMD decile of the incident based on the postcode of the placement recorded on the SIN. Of those incidents where neglect was recorded as a risk factor and IMD was known (n=142), a quarter (25%, n=36) occurred in the 10% most deprived areas in England and 84% (n=119) in the 50% most deprived areas. This is greater than where neglect was not recorded as a risk factor and IMD known (n=142), with 18% (n=26) occurring in the most deprived decile and 69% (n=98) in the most deprived 50% of areas. In addition, housing issues were recorded to be present in 38% (n=80) of incidents where neglect was recorded compared to 17% (n=32) of cases where neglect was not recorded as a factor.

There were several practice learning points identified within the reviews that were more prevalent in cases where neglect was recorded as a factor than in cases where it was not. This included issues around perceived disguised compliance (30%, n=63 compared to 10%, n=18), capturing the voice of the child (55%, n=114 compared to 41%, n=75), poor escalation of concerns (58%, n=122 compared to 45%, n=83, and lack of professional curiosity/asking the second question (78%, n=164 compared to 67%, n=124).

The Panel has recently initiated a piece of work around neglect which will consider the characteristics of families of children subject to review and focus on what helps or hinders multi-agency practice and interventions in protecting the child.

3.49 Overall, 12% (n=46) of incidents involved gang-related and/or youth violence and 9% (n=35) involved child criminal exploitation. Twenty-seven of these cases involved both elements. In 15% (n=57) of reviews the partnerships identified a victim/perpetrator overlap, where the child, as well as being the victim, had also previously committed crimes. In 12% (n=46) of cases the child subject of the rapid review was known to Youth Offending services either at the time of the incident or previously. In our 2020 Safeguarding children at risk from criminal exploitation report, we found that a key issue was that practitioners were unable to gain a deep understanding of the complexity and danger within the children's lives. Evidence highlighted that spending time with children and getting to know them enabled for a more relaxed and less formal relationship between these practitioners and the children, helping to build trust. The Panel's evidence highlights that effective information sharing and ensuring the voice of the child is heard continues to be crucial in enabling earlier identification of children at risk of criminal exploitation, opening the door to early help for children and families.

3.50 In 10% (n=40) of cases, child-on-child abuse (of any kind) was an identifiable feature of the reviews, with the majority (8%, n=30) being extrafamilial in nature and 3% (n=10) occurring within the family (intrafamilial). The vast majority (90%, n=36) of these incidents involved children aged 11-15 years old (45%, n=18) and16-17 years old (45%, n=18).

Impact of COVID-19

3.51 The unique challenges presented by the COVID-19 pandemic continue to have a significant impact on children and young people, families, and the wider community. Agencies working in child safeguarding continue to adapt to maintain support for vulnerable children and families. Our 2020 Annual Report highlighted the resilience, creativity, and adaptability of safeguarding partners in maintaining effective support for vulnerable children and families. We also identified 4 key factors, which combined, increased vulnerability and risk:

- parental and family stressors
- exacerbated vulnerabilities for children and young people
- impact of school closures: identification of, contact with, and support for vulnerable children and young people
- impact of adaptations for COVID-safe practice

3.52 Two years on from the start of the pandemic, rapid reviews for incidents in the reporting period of April 2022 to March 2023 suggest an ongoing impact to children experiencing death or serious harm due to neglect and/or abuse. The rapid reviews suggest that there may have been a COVID-19 context and impact on the life of the child because of the pandemic in 8% (n=32) of incidents. This includes incidences

where children remained out of school following the ease of pandemic restrictions as well as a lack of visibility of the child across services.

3.53 Overall, the reviews identified that COVID-19 had an impact on service response in 20% (n=78) of cases, mainly related to restricted service provision across agencies and the change with which assessments were conducted i.e. no longer in person. During the lockdown period, effective work with children and families emphasised the importance and impact of direct help and support for vulnerable families from practitioners.

Summary

3.54 There were 393 SINs and rapid reviews submitted for incidents that occurred between April 2022 and March 2023 with around two-fifths of these due to the death of a child which was related to abuse and/or neglect and around three-fifths due to serious harm where abuse and/or neglect is known or suspected. In over three-quarters of cases the family of the child was known to CSC either as an open case or previously, and a third of children were either on, or had previously been on, a CPP. In addition, nearly a fifth of children were classed as looked after either at the time of the incident or previously. We have identified several risk factors present in the lives of these children, for example mental health needs, especially amongst teenagers, ongoing neglect, and absence from school. In future reports we hope to look at these issues in greater depth to better understand children's experiences and how well the system helps and protects them.

4. Quality of reporting and reviews

4.1 This chapter reports on data collected by the Panel to maintain oversight of how the notification and review system is working, reflecting on timeliness or reporting, general quality of submissions and the inclusion of key characteristics of the child.

Key findings:

- The Panel are encouraged that 78% of rapid reviews had a completion date of within 15 working days of incident notification, and overall, 95% had a completion date within 20 working days.
- Safeguarding partnerships are, overall, making good decisions about progressing rapid reviews to LCSPRs. We agreed with 89% of the decisions made by safeguarding partnerships as to whether an LCSPR was needed. However, the Panel feel that recommendations emerging from LCSPRs may not be sufficiently clear, robust, or measurable and lead to the changes required to improve practice, thereby better protecting and supporting children and families.
- While many safeguarding partnerships are including relevant information and learning in rapid reviews and LCSPRs, we continue to see too much emphasis placed on detailed chronologies that reflect agencies' contacts rather than sufficient analysis of what happened and why agencies in too many cases collectively missed opportunities.
- Most frequently, the Panel has identified insufficient attention being given to a child and families' context, history, and perspectives. The Panel has also observed that reviews often focus on a specific incident or episode rather than evaluating the impact of family history and experience over time with different agencies. This can lead to a somewhat narrow and episodic approach which is less likely to yield effective learning for safeguarding agencies and, as a result, improvements in practice.
- Relatedly, we saw that while 95% of rapid reviews recorded the ethnicity of the child at the centre of the rapid review – an increase on previous years – this did not always translate into the review considering its impact on practice. We suggest that there needs to be further exploration of the significance of the role that race, systemic racism, ethnicity and culture played in services' response to risk assessment, decision-making and the quality of support offered to families.

Timeliness of notifications and rapid reviews

4.2 Both Working Together (HM Government, 2023) and guidance on reporting a serious child safeguarding incident state that the local authority should notify the Panel within 5 working days of becoming aware of an incident where a child has died or been seriously harmed and abuse or neglect is known or suspected.

4.3 The following figures are based on the difference between the incident date and the SIN date, although it is acknowledged that local authorities may not become aware of the incident on the date it occurs. Of the 393 SINs submitted for incidents that occurred between April 2022 and March 2023, 386 (98%) had a recorded notification date. Of these, 41% (n=159) had a notification date within five working days of the incident date. Overall, 90% of notifications occurred within 32 working days of the incident date and the average length of time was just over 21 days.

4.4 Local authorities are expected to notify the Panel of any case subject to a rapid review prior to its submission. In circumstances whereby we have not been notified, we will request that a retrospective notification is submitted. Overall, 9% (n=37) of SINs received by the Panel had a notification date that was later than the date of the rapid review, suggesting these were done retrospectively.

4.5 There is also an expectation that local authorities submit notifications using the online Department for Education's child safeguarding incident notification system. Although most local authorities are now using the online system, 4% (n=16) of notifications were made using alternative methods. Online notification of incidents is important as it ensures that they are included in the Department for Education's official annual statistical release of SIN data and allows the Panel, Ofsted and Department for Education to independently access SINs to carry out their official functions. Where there have been local issues with online reporting Department for Education have worked with local authorities to resolve these.

4.6 Rapid reviews are expected to be completed and submitted by safeguarding partners within 15 working days of notification by the local authority. Excluding cases with a missing review date or those where the SIN was submitted retrospectively, over three-quarters (78%, n=271 out of 348) had a completion date of within 15 working days of notification. Overall, 95% (n=330) of rapid reviews were completed within 20 working days of notification.

Quality of rapid reviews

4.7 The Panel's guidance on reviews highlights that rapid reviews should provide a succinct summary of facts, collating relevant information and provide a reflection on the case. The report must contain enough information to identify learning, consider immediate action and decide whether a Local Child Safeguarding Practice Review (LCSPR) is needed but not so much that it loses focus on these purposes. Of the 393 rapid reviews received for incidents occurring between April 2022 and March 2023, the average number of pages was 12, with the shortest being three pages and the longest being 54 pages.

4.8 Of the 393 rapid reviews conducted for incidents occurring between April 2022 and March 2023, 386 (98%) recorded whether the review should proceed to an LCSPR. In two-thirds (67%, n=258) of these cases, the safeguarding partners decided that an LCSPR was not needed, conversely, partners decided that an LCSPR would be required in one-third (33%, n=128) of cases.

4.9 Following consideration of the rapid review by the Panel, the safeguarding partners will be sent a response to say if we agree with the decision to proceed to an LCSPR or not. Out of 303 rapid reviews assessed for this decision, we agreed with 89% (n=271) of the decisions made by safeguarding partners. Of the 11% (n=32) reviews where we disagreed, the majority (75%, n=24) were for instances where the safeguarding partners had decided an LCSPR was not needed, however, the Panel identified that there was scope for additional learning. There were also eight occasions where a partnership had decided that an LCSPR was required, however the Panel felt that there was limited additional learning to be gained from an LCSPR as key learning points had already been identified within the rapid review and therefore advised that one may not be necessary.

4.10 The response letter from the Panel to the safeguarding partnership will also often reflect on the quality of the rapid reviews. The following themes on the quality of the reviews have been identified from the analysis of 223 response letters. Many safeguarding partnerships were commended for including relevant information, analysis and learning. However, the Panel continues to highlight that there can be too much detail in chronologies. These are often primarily structured around each agency's contacts rather than providing a more coherent overarching picture. In turn, some rapid reviews provided insufficient analysis of what happened and why to inform learning and to improve practice. In line with our guidance on writing rapid reviews, we recommend that partnerships submit a single, concise report which outlines an integrated chronology of significant events together with an analysis of the key issues/learning and any related action plan. The Panel also reflected on the lack of clarity and analysis in some reviews and encouraged partnerships, if they are proposing to undertake an LCSPR, to be clear, based on the rapid review analysis, about proposed lines of enquiry.

4.11 Feedback from the Panel also highlighted that there are often crucial details missing about the context of the child's experiences. The Panel encourages partnerships to explore the child's and wider family's perspectives and experiences throughout the rapid review process. This is also reflected in our guidance which highlights rapid reviews should focus on the child's lived experience and their perspective within the review.

4.12 A further theme in feedback from the Panel about some reviews centred around whether race, culture, faith and ethnicity of the child and/or family was sufficiently well considered by practitioners and if there had been good consideration in reviews of the impact of these issues on practice. The need for further and more detailed exploration of the significance of the role race, racism, ethnicity and culture in children's lives, in risk assessment and decision-making and the support given to families is considered further in Chapter 5.

Quality of LCSPRs

4.13 Overall the Panel has seen some improvements in the quality of LCSPRs. The best reviews are those where the safeguarding partners and terms of reference are focused on clear lines of enquiry, bringing together evidence from the individual case, and triangulating this with evidence of other system issues in their areas, as well as other research and the Panel's national reviews and thematic analyses. High quality LCSPRs also include clear recommendations that translate into specific actions with accountable owners, and which are designed to impact clearly on practice. They also have a clear strategy described for evaluating this impact.

4.14 However, the Panel finds that some LCSPRs are still weak in the analysis of why things go wrong, focusing on the chronology of events rather than the 'why'. LCSPRs should also define and carefully describe complex concepts, such as 'disguised compliance' and 'professional curiosity', for example, to ensure understanding what is meant by these terms in relation to a specific review. Most reviews continue to focus on learning for practitioners and to some extent local safeguarding systems. We see very limited consideration or analysis of the role and accountability of senior and middle managers and learning that may be specific to them.

4.15 The Panel also recommends that safeguarding partnerships consider publication of the LCSPR from the very outset of the review. This should consider any other processes that may still be ongoing and how, alongside these, the review can still be completed in a timely way. It is important to reflect at the outset on how a review might be written so that it does not undermine a child's wellbeing and welfare. This can often be achieved through removing intimate and personal details of a family's life as suggested in our guidance.

Inclusion of key demographic characteristics

4.16 Child Safeguarding Practice Review (CSPR) guidance for safeguarding partners on writing rapid reviews highlights the importance of recording key characteristics of a child's identity, such as sex, gender, ethnicity and whether there was a known disability of the child who died/was harmed. We also suggest that important issues to consider include:

- How was the race, culture, faith, and ethnicity of the child and/or family considered by practitioners and managers, and how was this considered in the assessment and practice response?
- How did any disability, physical or mental health issues, and any identity issues in the child and/or family impact on the child's lived experience and on practice?

4.17 Overall, 95% (n=372) of rapid reviews for incidents occurring between April 2022 and March 2023 recorded the ethnicity of the child. However, this did not always translate into the review considering their impact on practice and decision-making. This issue was a key finding in our qualitative analysis of reviews and is discussed in Chapter 5 (practice theme 'Race, ethnicity and culture').

4.18 We observed some examples where the ethnicity of the family does not feature in the characteristics described in the rapid review, even when information has been included in the initial serious incident notification to the Panel. Again, this suggests that issues relating to ethnicity and the impact of culture may not be being addressed appropriately.

4.19 It is important that rapid reviews consider how issues relating to race, racism, culture, faith etc. shaped families' and children's lives, experiences, and views, and practitioner's decision-making. The inclusion of such data and information can contribute to knowledge and understanding of broader aspects of practice and to help ascertain whether there are systemic practice issues to be addressed.

4.20 In our 2020 (CSPRP, 2021a) and 2021 (CSPRP, 2022a) annual reports, there was a concern that issues relating to ethnicity and culture were not being addressed if they are not recorded. It is important that a rapid review discusses if and to what extent the characteristics and cultural background of a child and/or family may have impacted professional decision making.

4.21 Intersectionality – how a child's social identities such as race, sex, gender and sexual orientation interconnect – is important for safeguarding partners to consider in relation to how it may contribute to the vulnerability and daily life experiences of the child. In addition, it is important that equity of action and decision-making by practitioners and managers is considered by safeguarding partners. This is discussed further in Chapter 5.

4.22 In 7% (n=28) of reviews the child was recorded as having a physical disability, but it was often unclear what the disability was or whether it was a diagnosed disability. Capturing children's disabilities is paramount for informing practice and addressing any vulnerabilities that a child with a disability may have. In 2021 around 11% of children in the UK were recorded as having a disability. Our report Safeguarding children with disabilities and complex needs in residential settings highlighted how children with a disability are at increased risk of abuse, particularly those who have difficulty in communicating needs and trauma (CSPRP, 2022g). This raises the concern that issues relating to children's disabilities are not being addressed. The Panel recommends that disabilities of children are not only recorded but explored in rapid reviews to ensure that services provide appropriate support to children with disabilities.

4.23 Overall, 3% (n=10) of children in reviews were recorded as being LGBTQ+ with the proportion increasing to 6% when looking at children aged 10 years old and over (n=10 out of 167). This is in line with national census data, where 3% of the population identified as LGBTQ+ with this increasing to 7% amongst 16 to 24-year-olds.

4.24 In total, only 3% (n=10) of children were recorded in the rapid reviews to have a gender identity different from the sex registered at birth or to be non-binary. Of these, all but one was recorded to have mental health conditions, either diagnosed or undiagnosed.

4.25 It is known that children who identify as LGBTQ+ or as a gender identity different from the sex registered at birth may experience a range of mental health problems at a higher rate than heterosexual and cisgender peers. The Panel highlights that it is important, therefore, both to record not only a child's self-reported gender and sexuality but also their experiences when assessing specific challenges and vulnerabilities they may face.

4.26 In general, it is difficult to establish whether the recording of key demographic characteristics is being accurately reported in rapid reviews as the lack of reporting may be due to the characteristic not being present or, it being present but not reported in the review. To enable a greater reflection on these key characteristics of the children involved, it is essential for practitioners to record conscientiously where these characteristics are not present, as well as present, in children. By acknowledging the absence of certain key characteristics, risk assessments and other key approaches can be strengthened and tailored to the child's specific needs and vulnerabilities.

Improving quality

4.27 This section has shown that there are several key issues around the quality of rapid reviews and LCSPRs including a lack of analysis around the 'why' and a focus on chronology or incidents in isolation.

4.28 In response, the Panel has been undertaking a range of activities to help improve the quality of rapid reviews and LCSPRs including:

- communicating with safeguarding partnerships through feedback letters
- disseminating newsletters to safeguarding partnerships sharing good practice
- providing good practice rapid review examples on our website
- listening to feedback from partnerships and other stakeholders through different events and incorporating this into our learning support offer
- delivering the Learning Support Capability which is focused on improving the quality of practice reviews

Summary

Overall, most safeguarding partnerships are conducting and submitting their rapid reviews within 15 working days of notification to the Panel. There are only a small number of instances where the SIN has either been submitted retrospectively or not through the online reporting system and we are working with partnerships to support them with this. The quality of LCSPRs continues to improve, although further focus is still required to ensure safeguarding partnerships look at the 'why' and have clear recommendations that set out how they will impact practice and how this will be evaluated. There is also still work to be done around the inclusion of key demographic characteristics, although the Panel is pleased to see that the reporting of child ethnicity continues to improve.

5. Cross-cutting practice themes

5.1 This chapter and Chapter 6 summarise the learning from Local Child Safeguarding Practice Reviews (LCSPRs) completed between January 2022 and March 2023 and rapid reviews for incidents which occurred in the same period.

5.2 The analysis focused on the six 'practice themes to make a difference' as set out in Chapter 1, as well as system strengths and challenges.

5.3 Several of the practice themes follow on from those identified in our previous national and thematic review reports, including the importance of effective leadership and culture. In last year's annual report, we identified the need for more in-depth consideration in reviews about the impact of race, ethnicity and culture on both children's and families' lives and on how professionals respond to their needs.

Six practice themes to make a difference.

1. Effective leadership and culture supporting critical thinking and professional challenge.
2. Giving central consideration to racial, ethnic and cultural identity and impact on the lived experience of children and families.
3. The importance of a whole family approach to risk assessment and support.
4. Recognising and responding to the vulnerability of babies.
5. Domestic abuse and harm to children – working across services.
6. Keeping a focus on risks outside the family.

5.4 In this chapter specifically, we present the findings and learning relating to the cross-cutting practice themes of effective leadership, race, ethnicity and culture and a whole family approach to risk assessment and support. In the following chapter we concentrate on the additional three themes: the vulnerability of babies; domestic abuse and risks outside the family.

5.5 The analysis looked at whether all these themes continued to feature in LCSPRs and rapid reviews and whether practice issues related to these themes might have manifested differently to how we have previously identified. We also share other emerging learning, present examples of good practice and pose a series of reflective practice questions for strategic leaders, senior and middle managers, and those working in direct practice with children and families.

LCSPR sample selection

5.6 For this report we have analysed 40 LCSPRs from a total of 144 that were completed by safeguarding partnerships during the period January 2022 to March 2023. We have used this period for the analysis to align with the same period used for the analysis of rapid reviews. While high-level analysis was undertaken for the full sample of rapid reviews with incidents occurring between January 2022 and March 2023, the main analysis of rapid reviews was conducted for those with incidents occurring between April 2022 and March 2023.

5.7 To help us select the 40 cases, we first captured key information from all 144 LCSPRs that were completed January 2022 to March 2023. This included socio-demographic characteristics (age group, sex, disability, ethnicity) and specific features of cases that would help us to explore the six practice themes, such as whether the case involved domestic abuse, or risks outside the home.

5.8 This information was used to select 10 cases featuring issues relating to race, ethnicity, or culture; 10 cases that involved babies under 12 months old; 10 cases that involved domestic abuse; and 10 cases that featured risks outside of the home. We selected cases to reflect as broad a range of characteristics as possible, seeking variety by age, sex, ethnicity and disability status. Table 5 provides the detail on how these characteristics featured in the sample.

Table 5. Characteristics of the sample of 40 LCSPRs

Characteristic	Category	Count	Percentage
Age group			
	Under 1	14	35%
	1 to 5	5	13%
	6 to 10	4	10%
	11 to 15	9	23%
	16 to 17	8	20%
	Total	**40**	**100%**
Sex			
	Female	20	50%
	Male	20	50%
	Total	**40**	**100%**

Characteristic	Category	Count	Percentage
Disability			
	Yes	8	23%
	No	27	77%
	Total	**35**	**100%**
	Unknown	5	
Ethnicity			
	White British	20	53%
	Other white background	2	5%
	Asian or Asian British	4	11%
	Black or Black British	5	13%
	Mixed ethnicity	5	13%
	Other ethnic group	2	5%
	Total	**38**	**100%**
	Unknown	2	
Harm category			
	Death	19	48%
	Serious harm	21	53%
	Total	**40**	**100%**

5.9 We then analysed the 10 LCSPRs for each of the following practice themes: race, ethnicity and culture; responding to the vulnerability of babies; domestic abuse and harm to children; and risks outside the home. Due to their cross-cutting relevance, all 40 cases were analysed to explore themes of critical thinking and professional challenge, and whole family approach to risk assessment and support.

5.10 In addition to the qualitative analysis of the LCSPRs, we also identified rapid reviews where the practice themes featured, and where system strengths and challenges were identified. This high-level content was analysed and compared with the findings from the LCSPR analysis to check consistency of findings across the review types. Content analysis was used to code the LCSPRs against themes and sub-themes identified in our previous reports. Further detail about the method used for qualitative analysis can be found in Appendix E.

5.11 It is worth noting that as many of the incidents which resulted in the LCSPRs being undertaken predate 2022, they took place before the learning from recent reports were published. This means that reviews may not necessarily always reflect current practice, but they reveal what learning was being identified and informing practice changes as a result.

Effective leadership and culture supporting critical thinking and professional challenge

5.12 Effective leadership and culture is the first theme under consideration in this chapter. Reviews continue to identify that good 'professional curiosity' and critical thinking is not always underpinning work with children and families, resulting in assessments and interventions that are not as robust and effectively focused on potential risks of harm to children as they need to be. Previous Panel reports have also highlighted a lack of challenge between professionals and an apparent reluctance to escalate concerns.

5.13 These issues bring into sharp relief the importance of building and sustaining practice cultures and relationships that encourage critical thinking and professional challenge across and within agency and professional disciplines. This is essential to securing good outcomes for children. It requires safeguarding leaders to model effective multi-agency leadership, ensuring that the right and necessary capacity and resources are in place. Leaders need to demonstrate, through engagement with practitioners, children, and families, that they have good knowledge about the quality of multi-agency practice and its impact on children. They also need to be assured that practitioners have access to high quality supervision with managers providing robust oversight, good support and challenge.

5.14 In this annual report, we have concentrated on what we can learn from reviews about how leaders can enable practice cultures which support and encourage professional curiosity and challenge. The pivotal role of leaders in setting the cultural 'tone' of practice was also considered in our national review on Safeguarding children with disabilities and complex health needs in residential settings (CSPRP, 2023b).

5.15 The revised Working Together guidance (HM Government, 2023) has introduced new national multi-agency child protection standards, as recommended in Child Protection in England (CSPRP, 2022c). Importantly too, it sets out new expectations about the roles and responsibilities of safeguarding partners. These changes are to be welcomed and should assist safeguarding leaders in making sure multi-agency arrangements work effectively to safeguard and protect children locally.

Key findings

5.16 All 40 LCSPRs in the sample were analysed in relation to this theme, as well as high-level analysis of rapid reviews where this theme featured. This analysis reflected similar issues previously identified in relation to critical thinking and professional challenge. The most common issues found in reviews were: a lack of critical thinking, professional curiosity and asking the 'second question' (this means in addition to asking ‘what’ is happening, asking ‘why’ is this happening? It involves looking below the surface to explore issues in more depth); failing to effectively escalate concerns; a lack of regular, good quality supervision and practitioners not challenging parents and carers in a sensitive way as and when necessary.

Effective leadership and culture

5.17 In this latest analysis we were particularly interested in understanding how senior leaders create the conditions necessary for effective critical thinking and professional challenge as well as how they promote a culture of learning which welcomes professional challenge. Given the importance of regular, good quality supervision we referred to earlier, we also wanted to consider any further learning and good practice identified in relation to that. We found that overall, there was limited commentary about these elements of leadership and culture in the reviews analysed, although the learning clearly points to the importance of enhancing leadership and culture to support practice improvements.

5.18 However, in relation to senior leaders creating the conditions necessary, we did see cases where practitioners would have benefited from more time, resources and training to gain knowledge, skill or confidence, both in relation to child protection conferences and multi-agency processes and in relation to specific areas of practice. Some examples that were referenced included intrafamilial child sexual abuse, so-called honour-based abuse, and complex mental health issues. Further training and support for professionals was also identified as being needed to support better practice when working with families where there were important faith considerations.

5.19 We saw examples where there was a lack of understanding and adherence to core principles of safeguarding among frontline police officers, including where children were being criminally exploited or involved in criminal activity. We recognise the unique role of policing in both safeguarding and enforcement, however, it is more often the enforcement approach that is identified as an issue within reviews. The Casey Review (2023) into culture and standards in the Metropolitan Police Service (the Met) also identified a need for police to emphasise the safeguarding element of their work especially when working with children suspected of criminal behaviour. The review also commented that the Met should provide training for all officers who work with children to prevent ‘adultification’, particularly with regard to Black and ethnic minority children. It is also very important that all police leaders, and other

safeguarding partners help practitioners have a good understanding about the impacts of trauma on behaviour and the potential for children to be victims as well as perpetrators of harm to others.

5.20 We found in some cases that earlier intervention by senior or middle managers in complex or long-standing cases might have resolved blockages and facilitated necessary action sooner for children and families.

5.21 We observed a weak translation of learning into practice, with previously identified learning not always leading to significant changes in practice and approach. Many safeguarding partners are working hard to address this issue and the Panel has seen evidence from some areas that in more recent reviews there has been critical evaluation of previous learning and good consideration about how best to create meaningful change. We anticipate that our new learning support project will assist safeguarding partnerships in securing impactful practice improvements from reviews.

5.22 Some reviews continued to show a lack of professional challenge between colleagues and between agencies. This included not challenging partner agencies' limited responses to ongoing queries or where they were not providing requested or necessary information to inform assessments and decision-making. There were also times when disagreements between agencies were not adequately resolved or escalated. Such circumstances identify an opportunity for safeguarding partners to proactively escalate issues upwards within the relevant agency. This lack of professional challenge between colleagues and agencies reflects the need for senior leaders to help foster an environment for safe professional challenge within multi-agency child protection conferences. There were also missed opportunities identified for appropriate professional challenge within individual agencies which agency leaders could encourage. Some reviews showed an absence of effective supervision and constructive spaces for challenging other practitioners and considering whether 'group think' might be affecting decision-making.

Case study: A suitable environment for challenge

An LCSPR examining the death of a child identified practitioners had missed opportunities to effectively challenge the parents about their relationship and their lack of engagement with required activities in child in need and child protection plans. The pattern of disengagement from various services prior to the serious incident was not fully appreciated and information not always shared proactively. The review also found that a productive environment of challenge for professionals was not present in the multi-agency space, with some practitioners feeling hesitant to express their views in conferences as they lacked training and were not able to be fully prepared before attending.

5.23 Child Protection in England (CSPRP, 2022c) drew on work that we commissioned from the Behavioural Insight Team to undertake a rapid review of literature about cross-agency working and information sharing. By looking at examples of where this has gone well and where it has not, 5 conditions for effective information sharing were identified. These were trust, shared values, and identity; leadership support; regular feedback loops; a clear information sharing policy; and systems that minimise the cost of sharing. The review highlighted that these conditions are not always present in the way in which child protection practice is organised currently. This work developed some earlier analysis commissioned by the Department for Education around decision-making in children's social work (Kirkman and Melrose, 2014).

5.24 Effective, joined up safeguarding leadership is pivotal in creating the conditions in which practitioners will seek, share and piece together information effectively, where there are high levels of trust and challenge and where there is honest and routine feedback about what is working well and what is not. By modelling collaborative behaviours and ensuring sufficient resources are available to support and sustain good information seeking and sharing across organisations, leaders are helping to create the ‘healthy’ environment that is so necessary for the difficult and complex decisions that practitioners and managers will make every day. Our recommendation in Child Protection in England (CSPRP, 2022c) for the establishment of multi-agency child protection units was based in part on the benefits of agencies working together more closely when analysing information, and bringing necessary rigour and critical thinking to very complex family situations where children are at possible risk of significant harm.

Good practice

5.25 Good practice was evident by some partnerships to encourage peer-to-peer support and group supervision across agencies. This was helping to increase practitioner confidence to be professionally curious, enhance peer learning and support learning, and have an understanding of other agency processes.

Learning

5.26 Given that the analysis focused on the role of effective leadership and culture in relation to this theme, the learning captured here is most relevant for strategic leaders and senior and middle managers.

- Senior managers and leaders being directly involved in complex or long-standing cases at the right time can help in progressing necessary action by addressing any blockages and supporting practitioners who may need additional assistance. The visible involvement of senior leaders in complex practice dilemmas and decision-making can be of real benefit and impact. By modelling reflective and analytic thinking when making complex decisions in high-risk situations, organisational leaders can demonstrate their support of practitioners.

- Encouraging a culture of appropriate and safe professional challenge (both across and within agencies) will help ensure decision-making and responses to children and families in need are robust and based on collective knowledge and consideration. Reviewing and reflecting on performance through evaluation at the end of multi-agency meetings can be a helpful way to encourage effective challenge and escalation.
- Continuing to examine how effectively learning is implemented into strategy and practice and evaluating the impact of this within partnerships will help leaders understand what works, and identify any further system changes required.
- Senior managers and leaders can facilitate the effective sharing of information across wider agencies, ensuring relevant arrangements are in place and, when in their scope of influence, built into local joint commissioning arrangements.

Reflective questions

- Given that the premise in Working Together guidance is that the review process should lead to learning being quickly identified and implemented in practice, how nimble and dynamic is the safeguarding system in your area in bringing about necessary change?
- How do you ensure emerging themes arising from reviews are addressed and factored back into the child protection system? How are you assessing whether practice is changing because of learning being identified? What else might help you to understand this?
- How do you assess the impact of training, guidance, and communications messaging within your agency and across the local safeguarding system to support practitioners and drive improvements to practice?
- Reviews often do not contain any reflection on the role, accountability and learning for senior managers and leaders specifically. What systems exist for reflection and scrutiny around this in your individual agencies and safeguarding partnerships?
- Do you know how confident practitioners are about providing positive challenge and escalating issues of concern? What did this look like when this has worked well?

Summary

5.27 The reviews in this latest analysis demonstrated mixed practice regarding critical thinking and professional challenge and how leadership and culture can support this. There was evidence of good practice and system strength in a range of areas, and we have highlighted some learning and development opportunities in others which we hope will be useful to leaders and managers.

Giving central consideration to racial, ethnic and cultural identity and impact on the lived experience of children and families

5.28 Our 2021 annual report highlighted the need to give greater weight to the impact of racial, ethnic and cultural identity, along with other intersecting factors such as poverty and deprivation to understand children's lives and how services have helped and protected them (CSPRP, 2022a). This is particularly important given that there is a higher prevalence of children from Black and mixed ethnic heritages in rapid review data compared to population census data (see Chapter 3 for a breakdown). Work commissioned for the Care Review found that, after controlling for demographics and social care history, mixed white and Black Caribbean children were around 30% more likely than white British children to have a child protection plan following referral (Ahmed et al., 2022). Importantly, the same study found that Black and Asian children were less likely than white and mixed ethnicity children to have been on a child in need or child protection plan in the 8 years prior to becoming looked after (Ahmed et al., 2022), indicating that they may not have been accessing preventative and early help support. The Care Review similarly described how although children from Black and minoritised ethnic backgrounds were overrepresented on CPPs they were underrepresented in early help services.

5.29 It is also of concern that previous and latest Panel analyses have shown that ethnicity is sometimes not recorded in serious incident notifications and rapid reviews, and that the impact of race, racism, ethnicity and culture is often not explored in depth in rapid reviews and LCSPRs. Understanding these issues and disparities is critical if we are to understand how and why some marginalised groups may find engagement with services challenging and why service responses may not meet their needs. The lack of data within notifications and reviews along with the key findings presented below highlight the importance and timeliness of the Panel's project on race, racism and ethnicity.

Key findings

5.30 A sub-sample of 10 LCSPRs were analysed in-depth in relation to race, ethnicity and culture, however, we also noted any specific issues related to this theme that featured in the other 30 cases in the LCSPR sample. We also include high-level analysis findings from the rapid reviews where this theme featured within them. It continues to be the case that race, ethnicity and culture are not given due focus or discussed at all in some LCSPRs, though attention to this theme was more common in reviews where the child and family were from Black and other minoritised ethnic backgrounds. In reviews where this was explored, a key focus tended to be on whether practitioners had considered the impact of race, ethnicity and culture and other characteristics in the child and family's lives, and whether practitioners had

understood the child's lived experience, wellbeing, and protection within their cultural context. Themes also emerged around biases and cultural assumptions which also extend beyond children and can impact how professionals engage with parents and families. The Panel think that reviews need to comment in greater depth on ways in which race, ethnicity and culture may have shaped children's experiences and on the response by agencies. These are important considerations for safeguarding leaders in helping to improve practice with children from Black and minoritised communities.

Invisibilisation and responsibilisation of children from minoritised communities

5.31 This 'invisibilisation' of some aspects of the lives and experiences of children from Black and minoritised communities means that practice is sometimes failing to recognise and respond to the specific needs of some groups of children, making sense of how culture, ethnicity, race and racism may affect a particular child and family. Furthermore, reviews suggest that practitioners are not always considering the harms and inequalities that can exist within child protection and other systems that shape children's experiences and responses to families. One review in the sample did argue that more needs to be done to address the social issues that children and families face, which limit the positive outcomes that practitioners can achieve. Some of the examples we discuss throughout this chapter indicate missed opportunities for services to have considered the wider social harms, inequalities and systems issues that children from Black and minoritised communities might have faced. For example, there was sometimes a focus on behaviour rather than what might be shaping that.

5.32 There is also evidence that some Black children are 'adultified', where practitioners hold children responsible for their actions without recognising their needs and overlooking their vulnerability as children by treating them as adults. This manifested in the language sometimes being used to describe children's behaviour – emphasising their choices and agency rather than their vulnerability and the potential coercion and exploitation by perpetrators. This can result in practitioners not focusing on children's underlying needs, for example focusing on practical considerations over psychological impacts or criminal behaviour over safeguarding and welfare of the child. This is an issue that we discuss further in the theme 'risks outside the family' in Chapter 6. However, in some reviews, efforts were clearly being made to avoid adultification, with an increased focus on using language that does not victim blame or place responsibility on the child. As a Panel we have consciously challenged safeguarding partnerships to be more considered in the language used to describe children, including asking partnerships to consider how rapid reviews are framed, for example by beginning reviews with describing the harm that has happened to children and always considering their vulnerability rather than commencing with narrative describing their potential criminal history. We appreciate the openness of learning on this issue that we see from safeguarding partnerships.

Case studies: Holding children responsible and treating them as adults without recognising their vulnerabilities.

1. Child Q is a Black British female who was strip searched at school in Hackney following suspected possession of cannabis. The review found that there were elements of disproportionality and racism that led to those involved making assumptions about Child Q. Practitioners demonstrated evidence of adultification bias by taking a criminal justice and disciplinary response to the situation as opposed to a child protection and safeguarding response. Child Q contributed to the review and placed emphasis on how she was 'just a child' who was 'supposed to feel safe' in school.
2. A 12-year-old girl was a victim of child sexual exploitation. The review revealed an overreliance on the child to report the abuse and an onus placed on her to keep herself safe, rather than any responsibility that could reasonably be placed on her parents (acknowledging the support they themselves may need in such situations) and the practitioners involved in her care. Records referred to the child 'seeking' and 'engaging' contact with adult men rather than recognising her exposure to coercion and control, and the influence of trauma on her behaviour. The child had a specific cultural heritage that was not named due to making the family identifiable within a small community. Despite this cultural heritage being known to professionals there was little exploration of what this meant for the child, her family and their experiences.

5.33 Although the examples we have included here focus on adultification in relation to older girls experiencing extrafamilial harm it is important for practitioners to recognise that adultification can also occur when dealing with boys, cases of intrafamilial harm and as something that can happen when responding to children from their early years upwards. Davis (2022) describes the differing contexts in which adultification can feature and which practitioners need to understand.

Representation and disproportionality

5.34 Children from minoritised communities may be underrepresented in receiving support and services; we have seen this in our analysis of rapid reviews which shows that children with Asian/Asian British ethnicities or other ethnic groups were underrepresented. One LCSPR, which explored data from the relevant local area, found that early help support was less likely to be available to those from Black and minoritised ethnicities. This echoes findings from other research that has shown that Black and mixed heritage boys were less likely than their peers to have been referred to early help services when they were younger (HM Inspectorate of Probation, 2021). However, the LCSPR also found that where help was offered and utilised, outcomes among those from Black and minoritised backgrounds tended to be better.

5.35 Within the LCSPRs, teenage children from Black and other minoritised ethnicities, particularly boys, disproportionately faced exclusion from school and authors emphasised how more needs to be done to understand the adverse impact of exclusion on this group. One review highlighted positive practice by practitioners in Pupil Referral Units who considered exclusion in the context of trauma and previous adverse experiences that may have impacted on the child's behaviour and responses. They also considered how the traumatic impact of being excluded could affect the child.

Understanding ethnicity, culture and racism

5.36 Some practitioners did not understand some groups' culture or their legal rights. In one example, a Traveller family was offered standard housing which contravened case law, exacerbated by a lack of policies in that area for working with Gypsy, Roma and Traveller communities. We saw an example where practitioners lacked understanding of a child's background and religion and did not realise the importance of this to them. Some practitioners lacked insight about intra-group differences in views and practices, for example, not recognising that different families from the same ethnic background may have contrasting views on domestic violence, leading to a lack of awareness and lack of exploration with individuals.

5.37 One review detailed assumptions made by practitioners about some people from minoritised communities as being 'westernised' without exploring what was meant. Another discussed a lack of understanding from practitioners about a Black Caribbean father's interest in 'Black magic' and alternative medicine. In the latter case, some of the father's views were known to be inaccurate and had been recorded by practitioners but they were not challenged. Due to these beliefs, his children did not receive immunisations and medical treatment was delayed for the child who was the focus of the review when she fell ill, leading to concerns that this delay was a contributory factor in her death. Some practitioners felt uncomfortable about the way the father's views were challenged after the child's death, and the review found that there was no shared understanding across the multi-agency network of how to address cultural beliefs. These kinds of assumptions and lack of understanding mean that assessments could be skewed and not based on what was actually happening in a family and to children. Some reviews raised questions about whether practitioners might lower their expectations about safety for a child in order to present as being sensitive to a child's ethnic group and culture. In one review this was manifested in practitioners not challenging parents when they raised culture as a way of distracting attention from the child and led to the practitioners involved prioritising culture above good safeguarding practice.

5.38 Understanding ethnicity, culture and the impact of racism may also require understanding the dynamics between families within geographical and cultural communities. For example, one review highlighted that practitioners did not

sufficiently explore a family's experiences of intra-community violence, and this led to difficulties in making any progress with the case; the family felt that they were treated unfairly and that wider issues within the community were not understood. The author of the review rightly acknowledged that practice is evolving and that some of the events relating to the case preceded the first discussion of contextual safeguarding in the 2018 publication of Working Together to Safeguard Children (HM Government, 2018). However, it highlights the need for senior leaders to ensure that practitioners are sufficiently trained and supported to adapt their approach to the needs of children and families where community relationships may be a factor in safeguarding and risk.

5.39 Some reviews cited examples of what they described as 'structural racism' and evidence that some children and families were treated differently by practitioners, possibly due to their ethnicity (please see Appendix A – Glossary for a definition of structural racism). Other examples linked to issues around race and culture included: disproportionate exclusions of children from Black and minoritised ethnic backgrounds in some mainstream schools; a Traveller family's cultural needs not being met regarding housing and a mother and child being denied housing in an area that they believed would have been available to someone from a different background. One LCSPR reflected on whether a family's experience of alleged violence and harassment within their community might have been treated as a hate crime if it had happened to other groups; the review recognised that the family may have been viewed as 'outsiders' but community dynamics were not explored by practitioners.

Communication and information sharing

5.40 Within a few reviews, some practitioners described a reluctance among some ethnic groups, including those from Asian and Traveller backgrounds, to disclose information, particularly to the police. This distrust of authorities was recognised to be a systemic issue and could be due to concerns that information would not be kept confidential or that there would be reprisals from the community. Consequently, cases could become 'stuck' and seem unable to progress. It could also lead to a perception among practitioners that there was little that they could do, as some communities resolve issues differently and that the concern was a 'cultural matter'.

5.41 At times, the importance of effective communication was not always recognised, and information was not always shared in a way that was accessible to people from diverse backgrounds and who had particular needs. This included people whose first language was not English and those who may not have had access to IT resources. In these cases, practitioners were not always working with families to ensure that information had been understood. Where practitioners felt that they did not have the cultural skills or knowledge required, there was not always an attempt to draw on external expertise, such as from community and faith-based organisations, which could have brought more knowledge about the culture and potentially more familiarity

with the family and their circumstances. More generally, reviews reflected that there was sometimes a lack of co-ordination and strategy across agencies when working with Black and minoritised groups.

Good practice

5.42 Within some LCSPRs it was clear that practitioners were addressing some of the challenges identified in some of our previous reports. There was evidence of some good practice in terms of how practitioners worked with children to understand their ethnicity and culture and how this shaped their lives and also some examples of good considerations of intersectionality (please see Appendix A - Glossary for definition). Examples included adopting a range of approaches to explore culture, such as speaking to children directly about their experiences or perceptions; practitioners sharing their own personal experiences; discussing the experiences of others, such as friends; or using hypothetical scenarios.

5.43 Practitioners drew on these types of approaches to explore a child's experiences and how these had been shaped by their wider community culture, including experiences that they may have had of racism and deprivation, and its link to other aspects of identity such as gender and socio-economic status. One review highlighted how children's experiences must be understood in the context of the cultural disadvantages they face; for example, gang activity may be a way of seeking belonging, rules and structure that children may lack within the home. These explorations of race, racism, ethnicity and culture would also focus on positive aspects of culture, such as the value of friendships between Black and mixed heritage boys and include celebrations of people's culture and background.

5.44 There were examples of practice which considered how exclusion and marginalisation are experienced by some children from Black and other minoritised ethnic backgrounds, influencing their behaviours and response to services. As we found in the Safeguarding children with disabilities and complex health needs in residential settings report, it is crucial that care planning for children recognises, understands, and responds sensitively to a child's racial, ethnic, and cultural background (CSPRP, 2023b). Positive practices were more often discussed in LCSPRs where practitioners had the confidence to undertake work with minoritised communities and could draw on their own or other's expertise. Examples of good practice were more evident where practitioners themselves were from Black or other minoritised backgrounds, or in areas where there were more children from ethnically and culturally diverse communities. Reviews also highlighted how it was helpful if practitioners were able to draw on wider expertise where it was needed.

Learning

5.45 Some of the following learning will help aid professionals when they are working directly with children and families. Other issues will be more relevant for senior leaders and managers in their work to promote inclusive and accessible services to all communities.

5.46 Learning for direct practice:

- Considering race, ethnicity and culture when exploring a child's lived experience can help ensure a more comprehensive and accurate picture of a child's life. It also provides an opportunity to consider the protective potential of culture, alongside wider cultural issues, and experiences of structural racism, and how these factors affect safeguarding practice.
- Taking care to consider how adultification and a child's experiences and potential trauma might impact upon their behaviour is important to avoid placing responsibility onto them and diminish the responsibility of perpetrators, carers, and professionals. Carefully choosing the language used when discussing, describing, recording, or working with children can also prevent conveying blame or responsibility on children.
- Working with families from different ethnicities and cultures to consider the structural, practical, and psychological barriers to engaging with services that they may face can help to strengthen engagement. This includes ensuring that materials and information take into consideration language, culture and access to resources.

5.47 Learning for strategic leaders and senior and middle managers:

- Including details about race, ethnicity and culture and how these intersect with other characteristics in LCSPRs will help to ensure that learning from reviews applies to all children and families and that the importance of ethnicity, race, racism and culture is not disregarded or overlooked. This should be considered from the point of commissioning reviews and the framing of key lines of enquiry.
- Senior leaders can support practitioners to gain the skills and competencies needed to work with diverse communities through:
  - providing space for practitioners within supervision to reflect upon their own identities and beliefs and how this may influence their practice
  - ensuring there are up-to-date policies and procedures for working with all ethnic and cultural groups relevant to their local areas as well as having access to the resources needed to provide information in a range of languages and formats as needed
  - ensuring that recordkeeping and documentation considers and records cultural background and identity

- ensuring that practitioners can draw on external expertise and support, such as community and faith-based organisations, where appropriate and where there is consent from the family – this includes creating links with these organisations and ensuring that they are invited to key meetings
- analysing data and other forms of evidence (for example, from case audits) to understand patterns in service delivery to different communities within their area, for example, are there differential patterns in how early help support is accessed?

Reflective questions

- How do you understand, including through the use of data, the diverse needs of your local communities? What gaps exist in the data available to you? What might this mean and how could you address those gaps?
- How does demographic information shape commissioning, service provision and your area's ability to engage and support different groups within communities. How do you ensure service design, provision and commissioning is relevant to all the communities in your area?
- What arrangements exist across your multi-agency partnership for engaging the support and expertise of external agencies, such as from community and faith-based organisations. Where and how might this bring enhanced cultural knowledge when working with children and families? Are these arrangements working effectively?
- How do your policies, practices and multi-agency partnership arrangements enable you to develop the skills, knowledge and confidence of practitioners to be effective in their engagement, assessment and support of children and families with different ethnic or cultural backgrounds? Can these be developed further to ensure that they offer equity to children and families from different ethnic and cultural backgrounds, while also ensuring they take into account individual needs and experiences?
- How can reflective practice, peer support and effective supervision enable practitioners to remain healthy, curious and objective, to ensure that children are not rendered invisible or are held responsible for their actions that may be perceived to put them at risk? How can you support practitioners to avoid using language that reinforces these views and challenge it where they encounter it?

Summary

5.48 While this analysis has shown that race, ethnicity and culture and their importance for understanding the lived experience of children are not always being explored within reviews, there were examples of good practice that demonstrate how some practitioners are making these issues much more central to their work. It is important that the Panel, safeguarding partners, and other stakeholders continue to develop and enhance our understanding about the impact of race, racism, ethnicity and culture on both the lives of children and families and how agencies, individually and

together, design and deliver services to help and protect children. Too often, our understanding and analysis remains somewhat superficial and very general in nature; this does not help children from Black and minoritised communities but equally it does not assist practitioners to deliver the very best practice. It is for this reason that the Panel is now undertaking work in this area, drawing on evidence from local reviews to identify ways in which current approaches might be enhanced. We look forward to working with safeguarding partnerships in the Panel's race, racism, and ethnicity project.

Theme: The importance of a whole family approach to risk assessment and support

5.49 While rapid reviews and LCSPRs focus on the child who died or experienced serious harm we know, and our data shows, that other children (such as siblings or relatives of the child who is the focus of the review) are indirectly affected by the serious incidents notified to us. Reviews can also point to where other children experienced harm or were at risk of harm and where opportunities had been missed to recognise those risks. This highlights the importance of integrated assessment which involves all members of the family and takes account of the dynamics within households.

5.50 The latest analysis reflects similar issues occurring in relation to whole family assessment that have been previously identified and referred to in our other reviews including the Myth of Invisible Men (CSPRP, 2021b) and Child Protection in England (CSPRP, 2022c).

5.51 The most common issues featuring in review reports in this latest analysis concerned assessments not involving all family members or carers and not considering the impact of identified vulnerabilities on household dynamics. Reviews featured a mixture of good practice and missed opportunities around building relationships with children and using their voice to effectively understand their lived experience and inform assessments and plans.

Key findings

5.52 The findings here again highlighted concerns identified in previous annual reports and thematic reviews by the Panel. This includes the need for practitioners to use the 'Think Family' approach: using holistic assessments to identify vulnerabilities for each family member and their impact on the family dynamics, which can in turn facilitate robust safeguarding plans. Some reviews identified that front-line practitioners are unaware of the 'Think Family' approach. The on-going need to engage with children and the men in their lives also featured in numerous reviews.

5.53 The absence of a whole family approach was evident across many of the reviews with services often focused on one specific family member, most often the mother or the child who was the focus of the review. When the focus of services is on the needs of the parent or carer, the needs of the child and the impact of parental vulnerabilities on their lived experience can be overlooked. Similarly, when practitioner focus is on the child alone, the vulnerabilities of the parents may not be sufficiently understood, and so necessary support is absent. In some cases, the focus was a result of practitioners seeing the individual as 'the risk' rather than 'at risk' (Brown, 2011). The vulnerabilities of other family members were not routinely recognised or included in assessments, nor was the impact of these vulnerabilities within the household always considered. This is a missed opportunity for services to gain insight into family dynamics and interconnected vulnerabilities, for example, when information and assessment between adult mental health and children's services are not effectively joined up. Reviews highlighted significant challenges for practitioners concerning the lack of communication pathways between services that provide support for children and services that provide support for adults. There were also examples of children not being recognised as young carers by services and we discuss this further in the 'Emerging themes' section of this report. These limitations are inhibiting child protection practitioners' awareness of parental vulnerabilities and risks within the home.

Case study: A Think Family approach

A young baby with complex medical issues died in hospital after becoming ill at home. The review highlighted that both statutory and commissioning services did not consider the needs of the baby's whole family in assessment and care planning. The commissioned care package did not factor in the needs of the older sibling. While there was evidence that the mother's voice was sought by her inclusion in discharge planning meetings and child protection conferences, her circumstances as a (potentially) single parent caring for a child with complex needs, as well as for the older child, were not considered in assessments or planning. Reflections on the relevance of her ethnicity and race on practice was discussed by professionals but not explicitly explored with the mother herself.

5.54 There was evidence of a lack of critical thinking and challenge concerning parenting capacity and the risk to children (particularly where parental drug and alcohol use was normalised by practitioners). For example, one review revealed how police did not share concerns with CSC about cannabis production within the home and the potential impact of this on the child. This was an issue raised in our report the Myth of Invisible Men (CSPRP, 2021b). There was also evidence of some practitioners losing their professional objectivity by over empathising with the vulnerabilities of parents. This issue as well as a general over optimism of practitioners about the ability of parents and carers to safely care for their children has also been previously identified

in triennial analyses of serious case reviews (Dickens et al., 2022a; Dickens et al., 2022b).

5.55 Many reviews found that practitioners were over-reliant on parental self-report - including cases where the voice of one parent is given more credence, usually the father. This was also found to be in the case in our Child Protection in England report (CSPRP, 2022c). In this latest analysis there were missed opportunities for services to triangulate such self-reported information, which at times was compounded by other relevant practitioners not being involved in multi-agency discussions (schools, GPs and domestic abuse services being the most common). The importance of questioning and testing parental narrative or practitioner understanding and potential bias is central to understanding the whole family picture.

5.56 'Silo' working in individual agencies at times led to missed opportunities for partnership relationship building and more effective co-ordinated multi-agency responses. This is an issue we continue to see across reviews, often in circumstances where a section 47 multi-agency strategy discussion was indicated but did not take place when it should have done, and where opportunities may then have been lost to intervene to protect a child at risk of significant harm. There was also evidence in reviews of agencies and professionals often acting in parallel or in sequence to each other when working with families. This can result not only in inefficient use of resources but most importantly it will have impact on collective capacity to help and protect children.

5.57 The absence of GP input and information from health records for all family members being available in multi-agency meetings was also identified as a common issue affecting the ability to recognise vulnerabilities impacting on the whole family. There are also times when information is not shared effectively within single agencies which has a significant impact on the protection of children at risk, such as a lack of information sharing between neo-natal units, midwives, health visitors and GPs in families with young children.

5.58 Some reviews revealed practitioners' over reliance on one parent to mitigate any risk to their children, with focus most often being on the mother. This was also the case where that parent was the one considered to be non-abusive or was the one being victimised themselves. In those cases, there needed to be a more nuanced consideration of the parent's capacity or ability to mitigate risk. Examples in reviews included circumstances where domestic abuse is or has been a feature in the household, as well as where the 'protective' parent had substance misuse issues and was caring for a child with complex additional needs. There were also examples where practitioners over relied on a domestic abuse perpetrator leaving the family home as providing safety for the child, failing to recognise the potential ongoing risk of contact regardless of whether or not the perpetrator lived in the same home.

5.59 We have previously emphasised the need for services to employ greater professional curiosity around fathers and their involvement in families and highlighted that gender stereotypes can underpin practitioners' assumptions about men's role and involvement in their children's lives (CSPRP, 2021b). Such curiosity must consider the risks they might present to children, but also their own needs and ability to be a protective factor. This curiosity is also essential in terms of knowledge about any new partners of parents, or indeed other adults with close and regular contact with the family, regardless of sex, gender, or sexuality. The latest analysis again reflected examples of practitioners not challenging fathers or other adult partners about their engagement, as well as accepting the mother's account of a separation or status as a single parent without triangulation.

Case study: Involvement of men in the children's lives

A 9-month-old baby was admitted to hospital with a non-accidental injury. Practitioners involved demonstrated consistent good practice concerning domestic abuse within the household. They triangulated information from both parents with other agencies, not always accepting the mother's first answer at face value. When the mother began a relationship with a new man and brought him into the home, both the police and CSC performed relevant checks on his background to assess any risks to her or her children. Through doing so services discovered another child was living in the home, who had inaccurately been believed to be the biological child of the new partner during initial inquiries. The circumstances of this child were investigated, and they were returned to the care of an appropriate relative.

5.60 The consideration and involvement of the extended family is often necessary for safeguarding. It is important for services to take seriously any concerns that they may have into account, as was highlighted in our report Child Protection in England (CSPRP, 2022c). Extended family members can be protective factors for children and their inclusion in safeguarding plans can be beneficial. However, practitioners must consider historical and current information about any such family members in their assessments, including whether there has been previous child protection involvement. It is also important to consider any evidence or information concerning risks of inter-generational abuse or offending.

5.61 While the child should be the focus of child protection activity, some reviews continued to show that the voices of children themselves were absent from service records. Direct and consistent engagement with children, both the child who is the focus of the review and any siblings where relevant, is critical. There were missed opportunities in some reviews for services to have used their relationships with other partners, particularly schools, to seek out and capture the voice of the children when there are obstacles to direct engagement. The analysis reflected some common

barriers to engaging effectively with children, including staff turnover and instability of care placements, and a general sense of some practitioners lacking the specialist skills to communicate effectively with children. This can be particularly challenging when working with non-verbal children (CSPRP, 2022f; 2023b). Following research with police looking at engagement with victims, colleagues at the Vulnerability Knowledge and Practice Programme published a Voice of the Child practice briefing (Brown et al., 2022) which may be of interest.

5.62 A further challenge identified in reviews is the lack of evidence of frequently used, well evidenced interventions. We see that reviews mention tools and interventions that are used and sometimes whether they were effective or not, but often there was limited or no information of the impact of those tools or interventions on practice.

Good practice

5.63 Some reviews highlighted the efforts of professionals to build relationships with children once they had disclosed abuse or investigations were underway. There were examples of agencies trying to work creatively to assess children, for example by looking at places they were comfortable to meet and actively addressing issues the children had highlighted as concerns and then communicating that directly to them. There was evidence of practitioners asking children directly what they were seeking help with and why, and going back to them to check if the professional response matched the children's expectations or if they wanted a different outcome.

5.64 The tenacity of individual professionals in raising safeguarding concerns with agency partners and to build relationships with families was also clear in some reviews. For example, some practitioners and agencies made determined efforts to ensure the consistency of professionals involved in a family's care. Another example concerned the effective engagement of a neighbourhood police officer to offer consistent support to a family and provide a multi-agency contact.

5.65 Good practice was also evident in some reviews where assessments reflected considered thought and understanding around domestic abuse, where wider family members could act as protective factors and in recognising the impact of trauma on a parent's capability to parent.

5.66 In some reviews schools were identified as key in providing safe spaces for children to talk about their home lives and worries, yet we also saw schools not always being included in multi-agency activity where they had valuable information to share or where their relationships with children and families might have facilitated multi-agency engagement. This points to the potential for schools and education colleagues to help facilitate contact between children, families, and other services, particularly where there has been a history or problems with contact and engagement.

5.67 The need for schools and other education providers to be included in multi-agency safeguarding arrangements was reflected in the recent Ofsted/Joint Targeted Area Inspection report focusing on early help and children in need. This suggested that local safeguarding partnerships need to ensure greater consistent engagement and strategic consensus with schools and other educational partners, who can be working in isolation to keep children safe. Operation Encompass is an example of specific safeguarding partnership working between police and schools enabling the latter to offer immediate support to children experiencing domestic abuse. Working Together (HM Government, 2023) has emphasised the important role of education providers in safeguarding arrangements. Further work is indicated to strengthen further the role of education in statutory partnership arrangements.

Learning

5.68 There is key learning identified here for practitioners, senior and middle managers and strategic leaders to consider when working with families and service design going forward.

5.69 Learning for direct practice:

- Assessment and identification of safety and support needs requires a broad and holistic view of the whole family (including fathers, other adult partners, extended family and other caregivers). Good multi-agency assessment and information sharing is also required to identify if extended family members may pose a risk to children.
- Understanding and considering the inter-connected nature of vulnerability is also important in deciding on the most helpful responses. The consideration of contextual issues like overcrowding, poverty, discrimination and racism is important in assessments. This helps understand a family's ability to cope given their own context and circumstances.
- Considering the voices and lived experience of all relevant children (those subject to support and protection as well as other related children in the family) is essential to good practice, as is listening to the perspectives and views of extended family members. Thinking about how the needs of either the child or their parent's impact upon other children and the wider family dynamics is necessary to identify their individual needs and what support they may require. Consider those practitioners who have an established relationship with the child (especially schools) to strengthen engagement.
- Involving other agencies and practitioners, such as GPs, schools, housing and domestic abuse services can significantly help develop the broader understanding of their circumstances and more effectively inform assessment and planning. Working with community organisations or consultants can be very helpful to add knowledge in circumstances where families include members with key

demographic characteristics. This can include drawing on their insight and knowledge to test hypotheses about what might be going on for the family and how any agency interventions may or may not be received.

- Taking care to fully consider and assess a parent or carer's capacity and ability to provide care for children and keep them safe is important. This can be particularly so in families where children have additional needs (including medical issues and disability), or there are features of substance misuse use, mental illness, personality disorder and domestic abuse. There is a need to be alert to children who may have caring responsibilities in a family and to consider what support they may need.

5.70 Learning for strategic leaders and senior and middle managers:

- Ensure that working with fathers, partners, and other carers, regardless of sex or gender, is embedded essential practice, rather than as 'extra' and that this expectation is shared across all safeguarding partners. Reflective and appropriately challenging supervision or other safe spaces can help ensure that practitioners consider not only individual vulnerabilities but how these might impact on family dynamics.

Reflective questions

- What systems and processes exist to capture the input of wider family members? Are they being used effectively? How is information from wider family members and about them shared in multi-agency engagement?
- What systems and processes are currently in place in your area (such as independent scrutiny) to ensure the voice of all children in families is heard and taken into account in assessing risk and need? Are they working effectively?
- How much does the training and support provided to practitioners in your partnership focus on the relational skills and confidence need to engage well with all family members? Are these skills included as key criteria when recruiting staff?
- How regularly and how effectively are other specialist services, particularly those related to mental health, alcohol and substance misuse involved in multi-agency decision making in your area or partnership? What can be done to build those relationships and address any barriers identified here?

Summary

5.71 This latest analysis demonstrates the on-going need for a whole family approach to safeguarding and child protection practice, taking due account of individual and family strengths, needs and vulnerabilities. New national standards for child protection, as recommended in Child Protection in England (CSPRP, 2022c), should support all safeguarding professionals in focusing on taking a whole family approach, whatever their role and agency base.

Chapter summary

5.72 In this chapter we have presented the findings and learning relating to the cross-cutting practice themes of effective leadership and culture, race, ethnicity and culture and a whole family approach to risk assessment and support. Our analysis demonstrated mixed practice in relation to these areas across safeguarding partnerships. We reflected on examples of good practice, particularly regarding the approach of practitioners, and drew attention to the role of safeguarding leaders in creating the conditions necessary for ensuring best practice in multi-agency working to support families and protect children.

6. Spotlight on thematic practice and other emerging themes

6.1 In this chapter we present the findings and learning relating the additional three practice themes we identified in our last annual report: recognising and responding to the vulnerability of babies; domestic abuse and harm to children; and keeping a focus on risks outside the family. We also discuss other emerging themes of note identified during our analysis.

Recognising and responding to the vulnerability of babies

6.2 Babies under the age of 12 months old comprised the single largest age group within the sample of rapid reviews (36%, n=142). The challenges associated with responding appropriately to this particularly vulnerable group have been emphasised in our previous reports, particularly the Myth of Invisible Men (CSPRP, 2021b) and Bruising in Non-Mobile Infants (CSPRP, 2022b). These highlight the need to understand the roles and risks pertaining to all adults around very young children. While gathering a full and comprehensive picture of families can be challenging, it is particularly difficult yet crucially important for those involved in the care of very young children and babies, as such young children have no voice of their own, they are entirely dependent on their carers, and situations can escalate rapidly.

6.3 The latest analysis continues to highlight issues with risk assessment and management not being effectively achieved in cases involving babies. There are overlaps with domestic abuse as pregnancy is a known risk factor in relationships with a history of domestic abuse, and exploring these issues can be challenging for professionals.

Key findings

6.4 The most prominent issues that emerged centred on the challenges practitioners face when exploring the vulnerability of babies with parents and wider family, and whether and how, they recognise contextual factors, such as parental mental health and trauma, when assessing the risk to babies.

6.5 Previous reports have highlighted how parental and family stressors were the most significant factor in escalating risk when it comes to safeguarding children under 12 months old. Consequently, identifying these stressors and responding to them is a key element of ensuring the safety of vulnerable babies. We sought to gather information on how practitioners were doing this and where there are gaps in practice.

6.6 Challenges in information gathering and sharing emerged as a key theme in this area, relating to information both within and between agencies. There were situations where vital information was not identified or sought; where information was partial or inaccurate; and where crucial information was not responded to. Reviews also highlighted communication issues and working with families where there were difficulties with engagement.

6.7 There was evidence that important information was not being identified, or sought, when practitioners failed to ask questions about domestic abuse or other potential risks, and where risk assessments were not undertaken when they should have been. These omissions could arise from a lack of professional curiosity around those close to the mother, and from practitioners taking information from parents at face value, without challenge.

6.8 It could also be difficult to ascertain whether practitioners had gathered information, due to poor record keeping and documentation. This was notably evident in relation to safe sleeping; there were instances where it was not documented who has been present during discussions on safe sleeping, safe sleep assessments were not included in health records, and it was not recorded whether advice was tailored to the needs of individual families. There were also instances where information about fathers was not included within reviews or risk assessments, and it was not clear if they had been considered.

6.9 Information regarding adults around the child was sometimes only partial or inaccurate. Paternity was sometimes recorded incorrectly and could be difficult to establish if the mother did not share this. There were several cases where genograms would have helped to establish crucial information about biological family members, or a chronology could have helped to establish the bigger picture.

6.10 Partial information was linked to insufficiently robust risk assessments. Some reviews described how poor or incomplete information could result from tools or toolkits – notably ones for safe sleeping and neglect – being inadequate or not being utilised fully. This could lead to missed opportunities to identify needs and was particularly relevant in relation to fully assessing parenting capacity and considering contextual factors and how they overlap, such as mental health and attachment, parental trauma and adverse experiences. Partial information could also result from key practitioners, most commonly GPs, not being involved in safeguarding processes either by not being invited or declining to attend. This highlights the opportunity for safeguarding partnerships to investigate why this is the case.

6.11 As raised earlier when discussing whole family risk assessment, there continues to be a real need for practitioners to fully consider any potential risk to children from fathers, any new partners of parents, or other adults with close and regular contact with the family, regardless of sex, gender or sexuality. This is particularly important when assessing risks to vulnerable babies.

6.12 Some reviews showed that practitioners did not always respond appropriately to information, leading to missed opportunities to prevent harm. Sometimes information was not fully understood or investigated further, for example when failing to recognise certain behaviours as signs of coercion and control. Findings were mixed however, as some reviews evidenced strengths around recognising vulnerability to domestic abuse, including coercive and controlling behaviour. In some cases, even where risks around domestic abuse and pregnancy were identified, no or insufficient follow up action was taken. Some reviews suggested that escalation policies were not clear or easy to use and may have hindered necessary follow up action.

6.13 Poor information sharing between agencies could mean that not all practitioners were cognisant of wider risks in the family. This is discussed further in the next section on domestic abuse. There was a notable lack of link up between child and adult services, such as probation and adult mental health, that meant important information on offenders was not shared. Transitions – between services and between areas – could mean that essential information was not shared with new services and that agencies were not being updated when there was a change in circumstances, including a family moving to a new area.

6.14 Agencies could also be slow in responding to information from some referrers, with concerned neighbours being provided as an example, suggesting a ‘hierarchy of referrers’ where information from certain sources is treated less urgently or given less weight.

6.15 Another theme that emerged was around communicating with families. For example, fathers were not always receiving the same level of parenting advice as mothers, and parents were not always able to understand the health needs of their child in cases of serious and life-limiting illnesses. Another example was a case where the non-offending biological father of an abused infant was not informed about concerns regarding his child’s care, thereby both failing to keep him updated and missing an opportunity to engage with him as a potentially protective factor.

6.16 A recurring theme centred on how best to work effectively with parents where, for diverse reasons, professionals experienced problems in engaging with them. This is an issue that is obviously not unique to working with families with babies. Fathers were sometimes described as demonstrating difficult behaviours that either went unchallenged or meant that they were not included in planning and care. Another key

concern was around working with mothers who did not appear willing to engage; this was sometimes cited as being due to parental 'overwhelm', with mothers particularly feeling there were too many professionals or services involved. Consequently, ascertaining the underlying reasons for disengagement or challenges in engaging (and having the skills to respond to this) was crucial but did not always occur.

Good practice

6.17 There were mixed findings in terms of how practitioners were responding to the needs of vulnerable babies and their families; although many of the concerns around seemingly invisible men that have been highlighted in previous reports were still evident, there were also some examples of good practice. These included persistent approaches in engaging parents, including mothers reluctant to engage, and asking questions around risks, including domestic abuse. There were also examples of practitioners successfully identifying fathers (including when the mother had resisted sharing this information or denied the relationship), engaging accordingly, assessing risk, and referring on if needed. Some examples of effective information sharing emerged, such as GPs being aware of safeguarding concerns and of child in need or child protection plans. In some cases, there was evidence of effective multi-agency working, with good attendance and contributions at meetings, joint working and effective communication and dialogue.

Case study: Exploration of vulnerability of babies under one

A 9-month-old baby was admitted to hospital following non-accidental injury. The baby's mother had significant vulnerabilities stemming from childhood abuse and exploitation and a history of domestic abuse. She had appeared reluctant to engage with services. Practitioners, particularly the social worker, were persistent in their attempts to engage and support the mother despite the signs of resistance. Concerns were discussed with her, recorded clearly, and her relationship with an abusive man was documented despite her denials of this being the case. Midwifery and Health were aware of the risks posed by both men in the mother's life (her current partner and father of the child who was the focus of the review, and her former partner and father of her eldest child) and across the partnership there was a good response to suspected abuse.

Learning

6.18 Learning for direct practice:

- Genograms are a useful tool that practitioners can use to record paternity and monitor any changes in paternal care. They can also be used to support professional curiosity around paternity.

- Ensuring that assessments take into account contextual factors that can compound vulnerability of babies can help to ensure that risks and parental stressors are fully identified and addressed. These include parental vulnerabilities, such as childhood trauma and mental health; characteristics such as poverty, race, ethnicity and culture; and external factors such as wider societal conditions.
- Communicating safe sleeping policies which are tailored to individual circumstances, clearly and fully to all parents and carers is important. Properly documenting what has been communicated to whom and when, can support further advice later if circumstances in the family or environment change.

6.19 Learning for strategic leaders and senior and middle managers:

- It may be beneficial for senior leaders to evaluate or review single or multi-agency toolkits used in work with families with babies and very young children, checking that they are up to date, fit for purpose and are being used correctly.

Reflective questions

- Are you confident that practice in your area (and tools and policies to support this) sufficiently assesses potential risks to vulnerable babies from fathers, partners of parents and any other adults with close and regular contact with the family?
- Is current practice to identify and respond to parental vulnerabilities such as childhood trauma, mental health and substance misuse effective? Do practitioners consistently apply this knowledge to help assess parenting capacity?
- Given the importance of all key professionals, including health colleagues, being involved in multi-agency strategy meetings and risk assessments concerning babies, how effectively is this working in your area? Are there any particular practitioners or agencies that are not as involved as they should be? If so, what are the barriers to involvement and how is this escalated to support resolution.
- Are those parents who are identified as having their own vulnerabilities, and who have babies with complex or life-limiting illnesses, being sufficiently informed and supported to care for them within the family home? How do practitioners know that parents fully understand their needs? How are disputes between health practitioners and parents regarding the best approach for caring for these babies resolved?
- We know there is a lot of work underway in the NHS to support families attending appointments and mitigating against children not being brought to key appointments. What financial and practical support do Integrated Care Boards or health providers offer in your area to ensure their service have equity of access to all?

Summary

6.20 The reviews have highlighted how some practitioners have demonstrated good work around identifying the vulnerability of babies, and there was also some evidence of effective multi-agency working. However, challenges remain, which hinder practitioners in identifying and responding to risk. Overall, the analysis highlights the need for practitioners to work closely with families, and to have access to appropriate tools to help understand their circumstances and factors that can lead to behaviours that are perceived by professionals to create difficulties in engaging with services.

Domestic abuse and harm to children – working across services

6.21 Although domestic abuse features in a high number of reviews, particularly those involving babies under 12 months old, it has previously not been one of the most common priorities identified by partnerships in their annual reports and was consequently made a key practice theme in our 2021 annual report (CSPRP, 2022a). Safeguarding practitioners need to be able to identify and respond to domestic abuse, particularly where this is either denied or minimised. They need to be able to recognise how domestic abuse differs from conflict, and how it can manifest in a range of behaviours, including control and coercion and other non-physical violent behaviours. It is also important to understand short- and medium-term risks and consider the long-term impacts of domestic abuse on both children and the non-abusing parent. This requires a co-ordinated multi-agency response, involving specialist domestic abuse services where needed.

6.22 The focus of the analysis undertaken for this report is on evidence from reviews about how practitioners are considering and responding to domestic abuse as it affects children, and in the context of the Domestic Abuse Act 2021.

Key findings

6.23 A sub-sample of 10 LCSPRs were analysed in relation to domestic abuse and harm to children. We also include high-level analysis findings from the rapid reviews where this theme featured within them. The most prominent sub-themes that emerged from the analysis centred on practitioners' exploration of the nature and context of domestic abuse to inform assessment; the use of combined multi-agency approaches bringing together child protection through the multi-agency risk assessment conference (MARAC), domestic abuse, stalking, harassment and honour-based violence assessment Tool (DASH) and perpetrator programmes; and recognising the long-lasting impact domestic abuse can have on children.

6.24 It was clear from the reviews that some practitioners have a limited understanding of domestic abuse, which is affecting their ability to respond in a timely and appropriate way. This may be exacerbated by approaches to assessing and responding to domestic abuse that may not be suitable for some circumstances, such as when the perpetrator is not an intimate partner (e.g. a parent's sibling or friend), or when both parents perpetrate abuse. This was reflected in some practitioners' binary and gendered approaches to domestic abuse which appeared to make assumptions about who the victim may be, or which did not fully consider relationship dynamics. The nature of relationships and victimisation in domestic abuse can be very complex and nuanced, requiring skill to explore, understand and assess risk appropriately.

6.25 Limitations were also seen in cases where parents have co-parenting responsibilities; there tended to be a focus on removing the perpetrator ('separate and isolate') without considering whether this may in some regard be harmful for the children, particularly if the perpetrator may also have some protective role in their care. For example, in a case involving a child with a serious medical condition, practitioners did not systematically consider the impact of the father being excluded from the family home due to domestic abuse perpetrated against the mother. In the review, the father was described as having a strong relationship with his children and as being the more organised parent in some elements of their care. When he left the family home this 'left a gap' in the care of the child who was the focus of the review, whose death was linked to the suspected neglect of his condition. A tendency to focus on risk by removing the perpetrator could also reflect a static rather than dynamic perspective on domestic abuse, for example not undertaking further assessment to establish whether children are safe once adults have separated. There was also some evidence of neglecting to consider how children have contact with a perpetrator parent after they have left the family home. Finally, reviews highlighted the lack of practice frameworks to assist practitioners when considering the long-term impacts of domestic abuse on children.

6.26 Reviews in this latest analysis also continued to highlight how opportunities to identify and respond to domestic abuse were sometimes being missed. For example, as discussed when considering the vulnerability of babies, practitioners were not always demonstrating awareness that a new pregnancy can be a risk factor where there is a history of domestic abuse. There was also evidence in some cases that the risk of domestic abuse was not being explored throughout pregnancy and postnatal care. Routine enquiries about domestic abuse were sometimes not being made after the initial booking in of pregnancy and this was acknowledged to be a national issue. By recording 'no domestic abuse' in the notes following an early appointment, health practitioners may have inadvertently been giving false reassurance that it is not an issue, with reviewers suggesting that it may be better to record 'no domestic abuse reported'.

6.27 There was also evidence that questions about domestic abuse were not being asked during checks with mothers if fathers were present. While including fathers in checks and appointments is essential to avoid them becoming invisible to services, this finding emphasises the need to ensure that mothers can speak to health visitors alone in case the presence of the other parent inhibits disclosure. While the specific review examples referred to fathers and mothers here, this same learning point can apply regardless of sex and gender of both parents or main carers. There was some evidence that professionals were not aways challenging parents when abuse was minimised and rationalised. There were also some missed opportunities to identify potential domestic abuse in healthcare settings, for example when women attend hospital with injuries for which there was no plausible explanation, which may have been an attempt to disclose abuse. GPs were also not always aware of domestic abuse when parents attend different GPs.

6.28 Limitations in information sharing meant that key agencies were not always aware of domestic abuse within families, where they may have had important information to share or a role to play. Examples included nurseries, schools and health services not always being aware of domestic abuse concerns, despite the significant contact they had with families.

6.29 Issues were identified about professionals not following proper procedures for Clare's Law disclosures, and there was also evidence of police responding to incidents in isolation and not recognising the cumulative effects of domestic abuse. There were also a number of issues identified with MARAC, such as poor co-ordination due to staffing issues and failures to refer cases, sometimes despite numerous incidents, due to their criteria for ‘high-risk’ cases only.

Case study: Use of combined multi-agency approaches

An 8-month-old baby girl was admitted to hospital after an anonymous call alleging physical abuse, with numerous fractures found. There were poor agency responses to reports of domestic abuse; following one incident, the police took no details of the abuse and shared no information with partners. Following another occurrence, a referral was made to children’s social care but no assessment or further action occurred. When the NSPCC made a referral, the shared police and children’s social care system was not checked. This system contained information on the risk the father posed from a previous relationship. There was a missed opportunity for services to pool their knowledge about the father and he remained unknown to MARAC as a perpetrator.

6.30 There were also examples of agencies not taking into consideration the context in which domestic abuse was occurring. This included police and other agencies failing to follow up domestic abuse incidents, and sometimes treating them as isolated incidents if they were deemed to be low risk, instead of recognising the cumulative impact of multiple incidents and considering the broader family history. Practitioners did not always consider the other stressors and demands on parents that can result in a tendency to disengage, such as parents feeling overwhelmed by the number of services involved with their family or the range of issues and challenges they were facing, which also emerged in the analysis on the vulnerability of babies. Nor was their response always understood in the context of the abuse that they had experienced. For example, in one review a mother relayed that her experience with services had reminded her of her experiences of domestic abuse, as she had felt 'bullied' in child in need meetings and 'attacked' rather than supported by the system.

6.31 Importantly, the impact of parental domestic abuse on children was not always considered or assessed, particularly the long-term impacts. In particular, the voices and perspectives of children who lived in homes where domestic abuse occurred was sometimes not captured.

Good practice

6.32 There were some system strengths associated with responding to domestic abuse found in the latest analysis, such as examples of good record keeping by GPs and good handover of services across county boundaries. Some cases highlighted effective and consistent engagement with families affected by domestic abuse. We noted above that risks around pregnancy and maternity were not always properly recognised by services, but there were also some examples where the recognition of the relationship between pregnancy and emerging or escalating abuse was well identified and appropriate responses made.

6.33 There were some other examples of good practice for this theme found across the reviews analysed. They included examples of agencies working to avoid a criminal justice pathway when the perpetrator was the victim's sibling and a child, with good partnership working by criminal justice teams and panels. There were examples of where police and maternity services alerted children's social care about domestic abuse, with the police recognising how the mother was struggling to cope and the potential impact on the child. There was also an example of effective support work carried out with the family by refuge practitioners where the mother and children were staying and good engagement by the social worker with the mother, children and refuge, despite being in a different local area.

Learning

6.34 We have identified from the review analysis some key themes for consideration by practitioners, managers and leaders.

6.35 Learning for direct practice:

- During health visits in pregnancy and at post-birth checks, health visitors should identify opportunities to speak to mothers (or other primary caregiver if applicable) alone to enquire about domestic abuse. If this is not possible it is important that the failure to hold the conversation is documented and attempts made for further contacts later and discussions to be held later, or with other professionals.
- Considering any negative impacts on, or increased risk to, children when the perpetrator of domestic abuse is prevented from contact or access to the home, can help to reduce any potential negative long-term impacts of domestic abuse. Where multiple professionals and agencies are involved with a family, ensuring there is co-ordination and communication across the professional network around the support and interventions taking place. This will avoid parents and children becoming overwhelmed, ensures the interventions are appropriate and professionals are held to account in terms of the progress and impact of their intervention/engagement.

6.36 Learning for strategic leaders and senior and middle managers:

- Where children move from one area to another, systems need to ensure that practitioners request and access previous records, including from children's social care, so that there are no gaps in safeguarding practice when families move
- Systems need to be in place that will alert nursery or early years facilities about any existing safeguarding concerns and plans for children newly registered so that they can contribute to multi-agency decision-making.
- Senior leaders may wish to review approaches and models for working with adults and children affected by domestic abuse, to ensure that they are effective for a range of relationships circumstances and dynamics, including perpetrators who are not intimate partners, children who perpetrate abuse, and abuse that is perpetrated by both partners.

Reflective questions

- What domestic abuse frameworks are used in your area and are these appropriate for the range of circumstances that can characterise domestic abuse cases? Can they be updated and improved in any way, with a stronger focus on the impact on children?

- What domestic abuse services have you commissioned in your area and is there an appropriate balance between those commissioned for adults/parents, and those commissioned for children and families more broadly?
- How well integrated is the relationship between specialist domestic abuse support services and the safeguarding system in your area? How well does this relationship work and do they support more than just the transfer of knowledge between agencies?
- What frameworks do you use to support practitioners in assessing the long-term impacts of domestic abuse on children? Do these fully include capturing the voice and perspectives of children?
- How does the system enable effective information sharing about risks from domestic abuse across boundaries when families and children move area?

Summary

6.37 While practitioners demonstrated some good practice when working with families where domestic abuse is a risk, there is still much work to be done. There was evidence that some practitioners continue to have a limited understanding of domestic abuse and its impact on children's safety and wellbeing. Our Multi-Agency Safeguarding and Domestic Abuse paper highlighted many of these issues and looks at emerging practice and interventions that aim to better safeguard children where domestic abuse is an issue in their lives (CSPRP, 2022f).

Keeping a focus on risks outside the family

6.38 Reviews continue to highlight themes relating to challenges and missed opportunities for protecting children from extrafamilial harm. Previous reports, including our review on safeguarding children from criminal exploitation, have highlighted issues around the role of safeguarding services alongside wider community services, collaboration between criminal justice and child protection frameworks, mental health, trauma and childhood adversity. These themes continued to be evident in this latest analysis.

6.39 A sub-sample of 10 LCSPRs were analysed in relation to this theme. We also include high-level analysis findings from the rapid reviews where this theme featured within them. The most common issues featuring in review reports related to practitioners not seeing beyond a child's presenting behaviours and focusing on their underlying needs; risk assessment of extrafamilial harm incidents and missed opportunities to use a contextual safeguarding approach (please see Appendix A - Glossary, for a full definition of 'contextual safeguarding').

6.40 Reviews featured a mixture of good practice and missed opportunities, particularly in identifying crucial transition points for children and young people, primarily within education and in moving from child to adult services. The latest analysis and previous reviews highlighted the impact of exclusion from school upon behaviour; this can escalate the risk of child criminal exploitation (CCE) by increasing the risk of manipulation by criminal networks (Child Safeguarding Practice Review Panel, 2020a). This was also highlighted in the Tackling Child Exploitation Support Programme Practice Principles (Research in Practice, 2023) which emphasise the importance of an immediate full-time education package for children who are excluded from mainstream school. The risks also apply to children who are not excluded but where they are absent for other reasons. As we saw earlier in Chapter 3, 29% of children who were the focus of rapid reviews and enrolled in mainstream school were reported as having regular absences or low attendance. This emphasises the wider risks of not being in school.

Case study: Exclusion from school

A 15-year-old boy who died by a fatal stabbing had numerous individual exclusions and a final expulsion from school following more than 300 different incidents in 18 months. Upon the move to a Pupil Referral Unit, they decided that they could no longer meet his educational needs because they were unable to regulate his behaviour. As a result, he was out of education from this point until his subsequent death. The LCSPR stated once he was out of education, 'things deteriorated very quickly' because the school was acting as a 'safety net'.

6.41 Some of our previous reviews and reports have referred to the limited research and limited guidance for local authorities about the most effective ways to respond to extrafamilial risk. The Practice Principles referred to above aim to help shape and inform the work of practitioners when responding to CCE and other forms of extrafamilial harm. They crucially place emphasis on the importance of multi-agency approaches to encourage better language and frameworks when working with children. The revised Working Together now clarifies the multi-agency response to all forms of abuse and exploitation from outside the home. It also clarifies the role of children's social care in assessing and supporting children at risk of, or experiencing, harm outside the home (HM Government, 2023).

Key findings

6.42 We know that CCE is an area of focus and developing practice for partnerships, as well as in researching what works effectively in this area. There has already been good progress in developing an understanding of the complex issues. In our latest analysis, we were interested in understanding how practitioners assessed and

planned for risks outside the family and several key themes were identified: focusing on behaviour rather than risk and need; the particular importance of professional relationships and effective engagement with children at risk; contextual safeguarding approaches not being used, or not used effectively; gaps in service provision; investigation issues and risk assessment.

6.43 Across the cases analysed we found issues with practitioners focusing on a child's behaviour which challenges, rather than sees, this as a potential sign of child exploitation. In these cases, behaviour was viewed as the issue to deal with and manage as opposed to exploring and understanding the underlying cause, which was often associated with vulnerabilities such as mental health. There were examples where practitioners referred to children as 'troublesome' or 'problematic' and where victim-blaming language was used in reports or case records. This was also highlighted in the recent HMICFRS report on the effectiveness of the police and law enforcement response to child sexual exploitation (CSE) which found the use of inappropriate victim-blaming language used in three of the 6 forces inspected (HMICFRS, 2023a).

6.44 Focusing on behaviour links closely to previously identified issues around a lack of professional curiosity where services have undertaken assessments with a narrow focus. For example, assessing ways to improve behaviour rather than identify and address underlying explanations. We also found that the complexity of the transition or cross over between 'exploited-exploiter' and the overlap between victim and perpetrator was not fully recognised, understood or explored by professionals.

Case study

An extract from one review highlighted victim-blaming and a lack of understanding or acknowledgement for the causes behind a young person's behaviour:

There was a culture of police officers and staff only seeing [child] as an offender and not seeking to understand why he may have become involved in such serious crime and disorder. For example, within one official document was the wording, "[child's] main danger is himself and his attitude. He has no respect for authority and will not be told what to do".

6.45 Practitioners and systems often failed to consider the intersectionality of different vulnerabilities experienced by children that increased their potential for exploitation and risk outside the family. For example, social isolation, mental health needs and exclusion from school or experiences of discrimination, disaffection and trauma and loss. Often vulnerabilities were seen as independent from each other with limited

consideration of how they interact, for example how special educational needs and neurodiversity can increase a child's support needs and risk of exploitation.

6.46 There were missed opportunities to address known risks outside the family on a multi-agency basis. These risks were not shared between agencies impacting the potential for a more comprehensive response. Referrals to the National Referral Mechanism or local child protection teams were not always made when they should have been.

Risk assessment

6.47 Within the reviews analysed there was sometimes a lack of practitioner knowledge around exploitation and risks outside the family. This impacted on the ability to identify vulnerability to extrafamilial harm and CCE and therefore the consideration of those vulnerabilities in assessments and planning. For example, not recognising the potential increased risk of exploitation for children excluded from school or children with neurodiversity. There was some evidence that even where risk assessments had taken place, there were issues around their timeliness or not considering all known concerns. Not all assessments recognised or evaluated the significance of family history, long-term support needs and parental capacity to manage the risks outside the family to which the child was exposed.

6.48 At the time of the serious incidents, or the reviews being conducted, local safeguarding systems and processes in some areas had not been appropriately set up to deal with risks of extrafamilial harm and exploitation. This resulted in the use of family and parental capacity frameworks or child in need and child protection plans to respond to extrafamilial risks. At times this led to insufficient recognition of the extent of risks outside the home and an over emphasis on the family's ability to protect the child. These issues were also raised in the Independent Review of Children's Social Care (MacAlister, 2022), with plans to improve the multi-agency response to extrafamilial harm laid out in the government's response (Department for Education, 2023j). The over reliance on the existing child in need process to manage risks outside the family meant related plans made little reference to important contextual risks and robust steps to address them. Surface level actions would be often listed, simply aspiring to keep the child away from the potential harm rather than detailing what and how actions would be taken.

Lack of effective engagement

6.49 We have previously identified that intensive and dedicated work with individual children and their families to build good relationships is a key feature when responding to children at risk of criminal exploitation (Child Safeguarding Practice Review Panel, 2020a). There were examples in this latest analysis of situations where practitioners might have done more to address barriers of lack of engagement

with children and their families. For example, practitioners sometimes simply repeated actions they had previously and unsuccessfully taken to engage with a child. There were also examples of situations where opportunities were not taken to maximise the support and expertise of multi-agency partners, including schools to support good relationships with families. Sometimes practitioners did not always capitalise on the opportunity when a child was relatively settled to build strong relationships with a child and family and which they could then draw upon later if circumstances become unstable. This meant that when there was a crisis it could be more difficult to engage with the child.

6.50 Contributing to the issues with engagement, our analysis revealed that there was often inconsistent staffing within services due to high staff turnover. Children did not always know who a particular practitioner was or why they were working with them. Additionally, some services expected a child to come to them and work with them on their terms which had an impact on the relationships between practitioners and children, thus impacting their engagement. Overall capacity in the system and practitioner workloads could also be a challenge impacting here. The recent VKPP report on Voice of the Victim (VKPP, 2023b) also identified how police colleagues found that demand limits their ability to engage effectively and compassionately with victims more generally to capture their voice.

Gaps in service provision

6.51 The analysis also identified a gap in service provision for children with complex mental health needs who do not have a diagnosed mental illness. This resulted in fragmented and unco-ordinated approaches which did not properly address the child's needs. It is recognised that in the UK, there is a lack of system capacity and which results in agencies prioritising children with a diagnosable mental health condition over those with emotional or behavioural needs (Hayes, 2020; NSPCC, 2014).

6.52 There were also evident service gaps around provision for children with special educational or behavioural needs with a lack of suitable placements and specialist schools and capacity issues within local authority teams for managing this.

6.53 In addition to gaps in service provision there are also issues with disproportionality in access to services that do exist. We described in the previous chapter and in Chapter 3 both the over and underrepresentation of Black and mixed ethnicity children in the child protection system. We also referred to the evidence indicating that Black boys disproportionately faced exclusion from school and that children from Black and other minoritised ethnic backgrounds are underrepresented in receiving early help services. Given these circumstances it is sadly not surprising to see the disproportionality of Black boys and boys from minority ethnic backgrounds still being criminally exploited. We raised this issue in our Safeguarding children at risk of criminal exploitation report back in 2020 and it continues to be a serious concern,

remaining an area of practice still requiring considerable improvement. Better data and understanding of this disproportionality at both local and national level continues to be needed so that necessary actions are taken to better protect this group of children. We encourage partnerships to continue to build on and respond to their understanding of how extra familial harm is affecting children in their area.

Investigation delays

6.54 We also identified issues around investigations such as significant delays during the investigation of offences and incidents relating to criminal exploitation or potential exploitation. During these periods, the risk to a child who was the focus of the review and other young people was not being proactively managed. Where multiple incidents had occurred concerning the child or young person a pattern of reactive response to individual incidents was identified in some cases. This meant that the extent and risk of criminality and exploitation in a child's life was not fully known or understood. Reviews suggested this is linked to a lack of capacity within policing to gather proactively intelligence about young people who may be at risk of exploitation. The Tackling Organised Exploitation Programme (TOEX) is new intelligence capability created to tackle organised exploitation and support the UK law enforcement and intelligence community. It informs investigations to help protect children and vulnerable people and pursue and disrupt perpetrators and should help safeguarding partners in addressing some of the risks to children identified here.

Mapping and peer relationships

6.55 A need for robust mapping has been highlighted as important for CCE because there is evidence that when one child in a group is moved out of an area owing to concerns around criminal exploitation, another child can take their place. In some circumstances mapping of a child's peer group would have allowed professionals to understand the links between the child and their peers and identify if others were at risk. In some cases, even when mapping occurred and cross-boundary relationships were identified, there was a lack of planning and mechanisms for cross-border working between agencies to help protect the children at risk.

6.56 The use of mapping in an online environment is also important and does not appear to be recognised fully by practitioners. We have found that the online environment and social media was not being recognised as a platform where a child can be exploited or may exploit others, instead it was viewed simply as a method of communication. Good practice would include mapping of the online environment as well.

6.57 The Contextual Safeguarding research team have published a toolkit on safety mapping, peer mapping guidance and other resources that can assist practitioners here.

Contextual safeguarding

6.58 There was limited evidence in some cases of a contextual safeguarding approach being used or being used effectively. For example, information about identified locations where offending and harm occurred was not routinely utilised as an opportunity for agencies other than policing to understand and respond. The analysis also revealed that at times professionals did not fully consider collective vulnerability of group of children with whom the individual child was associating.

Disruption

6.59 Activity to disrupt perpetrators can be hampered by a focus on behaviour rather than need, delay in investigations and police capacity limitations and a lack of mapping activity. Responding to risks of child exploitation requires a balance between criminal investigation and prosecution of perpetrators alongside actions to support safeguarding of children exposed to this kind of harm (Home Office, 2022). In our national review into children at risk from criminal exploitation we identified issues and a lack of action in disrupting and stopping criminal exploitation. We recommended that more priority be given to disrupting perpetrator activity.

6.60 In our national review we highlighted how knowledge around what intervention strategies were being taken against perpetrators of child criminal exploitation at the local level was limited, in marked contrast to the dual approach of taking action to help victims as well as disrupt activity in cases of sexual exploitation. The Child exploitation disruption toolkit is available to support frontline practitioners and sets out supportive information to assist information sharing and multi-agency working as well as intelligence and evidence gathering and profiling.

Good practice

6.61 Some cases analysed showed effective return home interviews being undertaken which demonstrated good support for the child and a willingness to share relevant information with police and children's social care. Community relationships held by neighbourhood officers were also effectively used to pursue lines of inquiry and progress investigations. In one case, a proactive alert was made to the local hospital regarding a child's vulnerability and exposure to risks outside the home. This helped ensure that any future presentation to hospital could take account of those vulnerabilities and risks when assessing the nature and implications of presenting issues.

Case study: Use of community neighbourhood officers

In a case involving two boys both aged 17, there was effective use of community relationships held by Neighbourhood Officers to pursue lines of inquiry and progress an investigation into an alleged assault. The intention of the neighbourhood policing team was to obtain more information about the boys to prevent gang associations and offending.

6.62 It was clear in some reviews that practitioners recognised exclusion and isolation from education as a significant risk factor in exploitation and therefore worked hard to ensure that there was an alternative education setting if a child had to be excluded.

6.63 There were also some examples of creative approaches being taken by practitioners to engage with children at risk of or experiencing CCE. This included local authority initiatives working with children and young adults to support them with their experiences of trauma from being victims of crime and exploitation, to break from associates or prepare them for the future.

6.64 One review described the efforts made to ensure support staff had the skills and knowledge to work effectively with children and young people where their ethnicity and culture was important to having a full understanding of their lives and how best to respond to their needs. Many attempts were made to provide professional support by engaging role models who were knowledgeable about culturally relevant issues for the young people.

Learning

6.65 Learning for direct practice:

- Many areas of risk outside the home can be complex and challenging to work within. Having a good understanding of what is involved in child criminal and sexual exploitation, modern slavery and trafficking and how this effects children, is important to identify and manage risks effectively. Specialist advice should be sought where required.
- A developed understanding of the vulnerabilities that could be present for children (and in their families) should always be the focus of understanding how to engage with and support children at risk of extrafamilial harm. Considering how their behaviour might reflect their experiences can help better understand what is going on and in building effective working relationships.
- Utilising disruption opportunities to disrupt the exploitation and abuse should be considered as a multi-agency approach. Any disruption activity should consider safeguarding needs of the child and their network to avoid unintended consequences.

6.66 Learning for strategic leaders and senior and middle managers:

- Working effectively to support children where they are at risk of extrafamilial harm requires skilled and knowledgeable professionals. Given the complexity of some of this work, good relationships and engagement with other specialist support services can enhance responses and tackle challenging issues.
- Gaps in necessary service provision can be a real challenge when trying to prevent risks of extrafamilial harm from escalating. Where there are known gaps it is important for agencies to work strongly and cohesively together to try and identify joined up solutions to manage risk and escalation in the interim.

Reflective questions

6.67 In our national review on safeguarding children from criminal exploitation, we identified a set of questions (pp 44-45) to help safeguarding partnerships assess the situation and their response capability in their areas; these may continue to be relevant to support local evaluation. Additionally, we encourage strategic leaders and senior and middle managers to consider the following questions:

- Is a contextual safeguarding approach well understood and is being utilised across your partnership? What works well? Are there areas where this could be developed further?
- How confident are practitioners currently about their knowledge of CCE, CSE, modern slavery and trafficking? What further input, support or training might be able to help address any knowledge gaps?
- Given the increase of child abuse and exploitation taking place online it is important that practitioners in all agencies recognise and understand the nature of this type of abuse. Do your existing training products, policies and procedures adequately cover abuse and exploitation in online environments?
- Are there any other areas of risk outside the family that are particularly relevant in your area? What systems and processes are set up to understand and respond to these on a multi-agency basis?
- What arrangements are currently in place in your area to help prevent permanent exclusion? Are these working effectively? What actions are being taken to address the needs of specific groups of children who may be disproportionately affected by permanent and short-term exclusions?
- Similar risks around extrafamilial harm can exist across similar geographical areas and where different safeguarding partnerships are working in proximity. How do you learn from what is happening in similar areas and how do you share learning from your own area that might be of particular benefit to others?

- There can be gender differences in the type of extrafamilial harm experienced by girls and boys as we showed in Chapter 3. This is relevant to the provision of local services. How well do you understand these differences? Is the balance between services for CSE and CCE in your area right to meet the needs of children experiencing or at risk of these types of harm?
- Similarly, there can be racial differences in experiences of extrafamilial harm which are relevant to the provision of local services. How well do you understand these differences? How well are children from Black and minoritised ethnic backgrounds represented in local early help service provision? How effectively do services meet their needs?

Summary

6.68 This latest analysis revealed both good practice and challenges that practitioners faced when assessing and planning for risks outside the family. Challenges focused mainly around missed opportunities for appropriate assessments and identification and management of risks. Some of these challenges appeared to stem from lack of capacity of services but others from a lack of practitioner understanding and inefficient or ineffective multi-agency systems and processes. It is very important that there is a well-understood and multi-agency contextual safeguarding approach to underpin responses to children at risk of harm outside the family.

Emerging themes

6.69 In this section we comment on some additional themes identified in our analysis of rapid reviews and LCSPRs. These relate primarily to specific groups of children and families.

Parenting capacity and children with disabilities and health needs

6.70 Reviews revealed how the parenting capacity of those who have children with health issues can be compromised by numerous factors: the stress of caring for their child, owing to the nature or severity of their needs; the lack of wider support; trying to care for other children in the home; and their own physical and mental health issues. Agencies should consider the circumstances and needs of parents of children with disabilities and/or health issues together with their capacity and ability to care for the child. This includes making sure that parents are well supported, including any help that they may require in understanding the needs of their children. In Safeguarding children with disabilities and complex health needs in residential settings, we highlighted how too often parents of children with disabilities and complex health needs are unable to access the high-quality local provision that may be required (CSPRP, 2022g; CSPRP, 2023b). The experience and circumstances of other children in the family also requires careful consideration, including consideration of their needs as a young carer where relevant (see below).

6.71 Several reviews have highlighted the risk of missing abuse and neglect when the primary focus has been on a child's health condition, for example, learning disabilities, asthma or diabetes. Children with health conditions will necessarily have been seen by different health, education and care services. This can result in fragmented understanding about what is happening in a child's life and the ability of parents to meet their needs. These issues were powerfully illustrated in the Serious Case Review about Hakeem which concluded that there was confusion among professionals around significant harm thresholds for neglect which increases where a child has a chronic medical condition that is being poorly managed by a parent (Myers, 2022). The hazards involved in not joining up information about children with complex health needs is illustrated further in the case study below.

Case study

A baby with complex health needs died of non-accidental injuries. The review revealed multiple missed opportunities to explore the parents' understanding of their child's condition and to assess their capacity to meet the child's needs. Midwifery/health visitors were not informed of the child's health conditions and therefore were prevented from supporting the mother effectively. Practitioners also overlooked indicators of abuse, owing to mistaken assumptions about the nature of the child's condition.

6.72 Practitioners can understandably default to a parent as the 'expert' in their child's conditions, however, this can mean missing or overlooking indicators for abuse and neglect. Practitioners may lack the specialist knowledge and training concerning the child's conditions. Not all professionals receive training on child development in sufficient depth and so may not identify concerns about a child's development and may attribute behaviour issues to their disability or health needs. There are two important issues here. Firstly, and as highlighted in the Panel's report the Myth of Invisible Men (CSPRP, 2021b), there remain concerns about the lack of adequate training in child development for many safeguarding professionals and this can affect their ability to identify and respond to physical abuse and indicators of neglect. Child development training about the mechanisms of injury continues to be very specialist. Secondly, reviews have evidenced that, when working with children with disabilities and health needs, practitioners may miss non-verbal cues and changes in behaviour resulting from abuse or neglect, falsely attributing them to the child's disability and health status. We saw this in our Safeguarding children with disabilities and complex health needs in residential settings report (CSPRP, 2022g; CSPRP, 2023b).

Children with complex mental health needs

6.73 A few reviews identified significant issues concerning children with complex mental health needs. In Chapter 3 we presented the findings from the rapid review data concerning mental health in teenagers and emphasised the importance of partners understanding the characteristics of the children impacted by mental health conditions to ensure the appropriate service provision to support them. The findings emphasised the high prevalence of mental health conditions for teenagers identifying as being LGBTQ+ and those recorded as having a gender identity different to the sex registered at birth or being non-binary. It was also evident that a significant proportion of teenagers with reported mental health conditions were also recorded as experiencing alcohol and/or substance misuse. We also saw how suicide was the cause of death for nearly half of those teenagers with mental health conditions who had died and that all the teenagers who had mental health conditions and had attempted or completed suicide or had self-harmed were known, either previously or at the time of the incident, to CAMHS.

6.74 Although that detailed analysis of rapid reviews concentrated on the mental health of teenagers in particular, rapid reviews and LCSPRs also reflected similar issues experienced by some younger children. LCSPR analysis highlighted a lack of available services, long waiting times and rigid thresholds for some specialist services which present consistent barriers to children receiving effective and timely help. Relying too heavily on a child's diagnosis to lead the safeguarding response may result in prioritising children who have a diagnosis, leaving those with evident but undiagnosed, mental health needs without the co-ordinated support needed.

6.75 Reviews also pointed to the national shortage of practitioners to perform assessments for diagnosis of mental health needs and neurodivergence as playing a significant role here. Gaps in adequate educational provision were also an issue across reviews impacting on the ability to effectively safeguard affected children from risks both inside and outside the home.

6.76 The findings across our quantitative and qualitative analyses indicate the need for safeguarding partners need to be aware of the impact of other risk factors and/or key demographic characteristics which may affect a child's mental health and risk of harm. Partners also need to provide support for children who face a long wait for assessment and diagnoses and for those with undiagnosed mental health needs, being alert to the variety of factors that may add to risk as well as those 'final straw' stresses that may lead to suicide or serious self-harm.

Case study

A 16-year-old girl sadly completed suicide in an inpatient care unit, which was the last of many mental health establishments in which she had resided over the preceding year. She was given numerous different mental health diagnoses during that time, with practitioners at one point believing she had no mental health diagnosis before this view changed to one relating to personality disorder. Mental health practitioners and children's social care (CSC) disagreed over discharge plans, as she refused to return home to her mother, but CSC identified no safeguarding concerns. The review found the CSC assessment relied on the mother's self-report and did not capture and reflect the girl's voice.

Parental mental health and parenting capacity

6.77 Parental mental health and their attendant parenting capacity can also be overlooked, with a need for practitioners to assess parents' awareness of their child's needs. Lack of effective pathways for communication between adult and children services can leave safeguarding partners without knowledge of the potential risks a parent may present to their children. When parental mental health is not fully considered or understood, services can also overlook the viability and practicality of parenting arrangements and safety plans. Parents struggling to meet the expectations within plans can then be framed as neglect, rather than as evidence of parents feeling that the demands of them from some agencies are overwhelming This issue was most seen in terms of expectations on mothers. Some reviews also reflected on the need for practitioners to consider the feasibility of co-parenting and safety plans when domestic abuse is a factor, and how former partners may use access to children as a means for coercion and control. In circumstances where parental mental health is a factor, it is also important that practitioners consider the possibility that the child is or may become, a young carer.

Children not in school

6.78 Issues around the recognition of risk associated with children not being in school have been discussed earlier in this report, including the link to risks outside the home and neglect. This is a persistent issue and one which has been highlighted in previous Panel reports. It includes situations where children have been excluded from school, where suitable placements cannot be found or are delayed, and where children are receiving elective home education.

6.79 We have seen how the risks of exploitation can be exacerbated when children are not in school. They can become 'invisible' to services where neglect and other abuse goes unnoticed. There can also be serious impacts on the mental wellbeing of children which can potentially further increase the risk of exploitation and vice versa.

The latest analysis demonstrated difficulties with a lack of suitable placements and support for children with complex needs, and stretched resources within special educational needs services. Case reviews continue to show that too many children spend long periods of time outside of formal education as a result. It is during these periods that some children die, or experience serious harm.

6.80 We highlighted earlier the critical role that schools play in supporting children, identifying safeguarding issues and maintaining effective engagement with families. We also described how multi-agency child protection systems are not always effectively involving schools and other education services. It is crucial that more is done to engage them in local safeguarding practice, drawing on best practice in involving schools strategically, and in day-to-day practice. This is important for those children who are potentially at risk and attend school, but it is potentially even more critical for those children who are not. The Panel has been analysing reviews where children were in elective home education, and will shortly be publishing the outcome of this study.

Young carers

6.81 A few cases in this latest analysis identified the caring responsibilities some children had within their families; where they are ‘young carers’, although they may not formally be recognised as such. This is an issue that has also featured in our regular Panel case discussions. Agencies are not always recognising this role for children and the impact this has on them. These children can be providing crucial support for their parents or other adults, sometimes where they have substance misuse problems, mental health needs or where domestic abuse is present, all which impact on their own capacity to support their children. Children sometimes take a parental role in caring for their siblings, including young children and siblings who have disabilities or complex needs impacting on their parents’ ability to cope.

6.82 Previous research, published by the Department for Education (Cheesbrough et al., 2017) and others (TNS BMRB, 2016), shows that children with caring responsibilities experience a range of both positive and negative outcomes and these are directly affected by the level of informal or formal support they receive. It highlights the challenge of identifying 'hidden' young carers and emphasises the need for all services working with vulnerable children and adults to take a whole family approach to assessing need. Identification can be hindered by parents and carers concerns about the consequences of disclosing young caring in families, fearing involvement by services and intrusion into family life.

6.83 More needs to be done across the safeguarding system to recognise young carers, the responsibilities they may shoulder, and how this can sometimes impact on their safety and wellbeing. The Panel will consider further how best to identify these issues in review data and analysis.

Working with Gypsy, Roma and Traveller communities

6.84 The analysis of quantitative data in rapid reviews, (discussed in Chapter 3), showed that no children were reported to have 'Gypsy or Irish Traveller' as an ethnicity. However, in our in-depth qualitative analysis of both rapid reviews and LCSPRs, we found several cases where children had family members who were understood to come from Gypsy, Roma or Traveller communities, and where this had an impact on the children's lives, community and upbringing. We identified some issues when practitioners were working with families from these communities. There were missed opportunities to explore the impact of cultural identity and community factors on individual children and families. For example, topics that may be gender-sensitive, such as sexual and reproductive health care, mental health and substance abuse can sometimes be considered taboo within some Gypsy, Roma and Traveller communities. Practitioners need therefore to bring sensitivity to discussion of these issues. Some reviews highlighted a need for enhanced cultural awareness and diversity training for practitioners relating to different cultures and ethnicities, including Gypsies, Roma and Travellers.

6.85 Cultural barriers meant that traditions and parenting approaches of Gypsies, Roma and Travellers, as well as those of other ethnic and cultural groups, were not always understood by services and rarely questioned. As such, sometimes there were missed opportunities to acknowledge something as a neglectful or abusive behaviour, with this instead being interpreted as parenting style. Conversely, other times where a behaviour that was not abusive or neglectful was flagged as a safeguarding concern. When challenges around parental capacity were identified sometimes parents were referred to universal parenting programmes, and interventions which did not always capture the way of parenting in Gypsy, Roma or Traveller and other ethnic and cultural communities.

Chapter summary

6.86 This chapter has summarised the findings of our latest analysis related to several themes concerning children with additional needs, and highlighted the importance of understanding and responding to parental capacity to provide safe care. Together with the findings of Chapter 5, this chapter has pointed to key areas of learning and opportunities for continually improving multi-agency leadership and practice when working with children and families. We hope the learning points highlighted and reflective questions posed throughout provide a helpful platform for safeguarding partnerships to consider the issues most relevant to children and families in their localities.

7. National reviews and thematic analysis

7.1 This chapter distils several important cross-cutting themes that have surfaced from our own national and thematic reviews undertaken in 2022, and which we consider here in light of the continued observance of these themes in the analysis of reviews that form the basis of this annual report. The purpose of the chapter is to reflect on 'what is going on' in the system and what needs to be done to improve the safety and protection of children.

7.2 The Panel delivered 2 major national reviews in 2022/23. The first focused on the lives and tragic deaths of 6-year-old Arthur Labinjo-Hughes in Solihull and 16-month-old Star Hobson in Bradford. Child Protection in England sought to keep strong focus on the unique lives and experiences of these 2 children, focusing on the role of safeguarding agencies and seeking to draw wider lessons about priorities for improvement in contemporary safeguarding practice. The Panel welcomes the way that the review's 8 recommendations are being taken forward by government and other stakeholders, for example, in the pathfinder programme and new Working Together guidance. It is in the interests of children that these changes are delivered with pace and make a difference to children.

7.3 The Panel's second national review focussed on children with disabilities and complex health needs living in residential settings. This group of children are often marginalised and hidden from public sight. What happened to them was undoubtedly shocking, but it was also scandalous that so many children were being abused and neglected in such plain sight. Most of these children were looked after by local authorities, and what was happening to them should have been known and visible to a range of public agencies. The Panel welcomes government's detailed and considered response, but it is vital that they, along with safeguarding partners, regulators and providers robustly assure themselves now and into the future that they are taking all the necessary actions to protect this group of children in the future.

7.4 The chapter centres around three key themes:

- Knowing what life is like for children, highlighting the centrality of children's voices and experience, and those of their parents, carers, and wider family members; but also, the knowledge, skill and confidence required to build a full picture of children's lives to enable the best safeguarding, support and protection.
- Information sharing and seeking which is a perennial issue in child protection and safeguarding work. Issues in this area undermine the ability of practitioners and agencies to have a full and accurate understanding of what is happening in children and families' lives, including any risks of harm.

- Working across agency boundaries, upon which information sharing is reliant, and which is essential for building holistic pictures of children's lives.

Knowing what life is like for children

7.5 Our national reviews and thematic analyses have consistently highlighted the centrality of building a comprehensive and accurate picture of children's lives to enable the best safeguarding, protection and support. Developing an understanding of children's lives must include listening to and hearing their voices, where this is possible. However, this also includes empowering parents to speak on behalf of the child where communication difficulties may prevent children from doing so themselves, as we found in our review on Safeguarding children with disabilities and complex health needs in residential settings (CSPRP, 2023b). It involves taking account too of the voices of wider family members who hold substantial information about the lives of children, but who are sometimes neglected in assessments and decision-making, as discussed in Child Protection in England (CSPRP, 2022c). It is important practitioners are equipped with the skills and knowledge to understand child development and the impacts of abuse, which can provide important clues about the lived experiences of children, as discussed in our thematic review Multi-Agency Safeguarding and Domestic Abuse (CSPRP, 2022f). This is particularly important in assisting practitioners to build a picture of children's lives who may be otherwise unable to communicate their experiences directly. Also crucial to building a picture of children's lives is the knowledge, skill and confidence practitioners need to explore how ethnicity, culture, racism, culture and other social factors may affect parenting, a child's experience and how services respond (CSPRP, 2022d; CSPRP, 2021c).

7.6 Across the reviews analysed for this report, we saw some real efforts being made to listen to, and include, the voice of the child who was the focus of the review in assessments, decision-making and in reviews themselves. There is scope to use this developing practice to ensure that the voice of other children involved in families, who may not be the direct focus of child protection activity, are also listened to and considered in plans and the provision of any support required to meet their needs.

7.7 There was also some clear and widespread evidence of the tenacity, creativity and innovation of both individual and groups of practitioners to engage and work effectively with children, and in some cases with parents, carers and wider family members. Notable efforts were made in some cases to maintain consistency among practitioners involved in supporting both the child and the family, despite the resourcing and practical challenges faced by individual agencies and multi-agency partners. The reviews reflected good developments in the consideration of 'invisible men' in the lives of children and their families, where critical thinking and challenge

were effectively deployed to understand the role and involvement of male partners, including their contact with children. We think there is an opportunity for more to be done to broaden out this good practice in relation to any adult who has regular and close contact with children in families, regardless of sex, gender or relationship to the child or their parent.

7.8 Practitioners need to be supported to think critically to avoid over reliance on parents or other family members to care for and protect children where they may lack the capacity or capability to do so, and enable earlier intervention when there is evidence a parent or carer is struggling to manage. This is especially critical when parents or carers have mental health needs, substance misuse problems or where domestic abuse is a factor. Practitioners need sufficient support to ensure that the narrative of a parent or carer is appropriately triangulated and critically reflected upon to test the validity of their accounts (CSPRP, 2022d).

7.9 In Child Protection in England (CSPRP, 2022c), we emphasised the need for practitioners to have specialist skills when working with families whose engagement is reluctant or sporadic. In our previous analysis of decision-making we found that establishing authentic 'support and challenge' relationships was key to having a timely response to changing risk. The evidence from this latest analysis of reviews reinforces the importance of developing those skills among child protection practitioners.

7.10 Having good understanding about what life is like for children involves understanding a family's history, the role of wider family members, the impact of trauma, and of culture and ethnicity. This is crucial to making sense of how these and related issues can impact on their behaviour and response to agencies. This will help build effective relationships with families so that the most appropriate support and protection is provided to children.

Information sharing and seeking

7.11 Building a full and accurate picture of children's lives is reliant on the effective sharing of the right information at the right time. It is also dependent on bringing together all known information together and making sense together about what this may mean about children's lives, and any risks of harm to which they may exposed.

7.12 Weaknesses in information sharing continue to be a key perennial challenge and was one of the 4 fundamental practice issues identified in Child Protection in England (CSPRP, 2022c), and in this analysis of rapid reviews and LCSPRs, undermining the quality of assessment and decision making.

Working across agency boundaries

7.13 Developing a collective understanding about children's lives itself is reliant on an effective whole system response, as highlighted across in the Panel's national and thematic review work in 2022. Our Multi-agency working and domestic abuse report, for example, highlighted the need to look at local safeguarding systems and responses to domestic abuse more systematically, rather than solely focusing on the 'front door'. Furthermore, Safeguarding children with disabilities and complex health needs in residential settings identified a need for effective, early multi-agency working to ensure that this group of children are enabled to access the right support at the right time (CSPRP, 2023b). Effective multi-agency working, or a whole system response, supports the shift away from an incident-based model of intervention to one that provides a deeper understanding of the on-going nature of abuse and harm and its impact on victims, as discussed in Child Protection in England (CSPRP, 2022c).

7.14 We saw many examples in this year's analysis of strong and effective multi-agency working where information sharing, assessment and decision making was timely, extensive, and based on good record keeping. This was often noted with regard to the police, children's social care and GPs, including some good evidence of GPs sharing and requesting information concerning domestic abuse. There were also examples of agencies working together to address situational and contextual issues, including those relating to education and to ethnicity and race in their areas to improve practice. For example, in one area, clear strategies had been developed to help identify and provide support for students at risk of permanent exclusion, underpinned by work to regularly review data and understand disproportionality and trends in school exclusion for Black boys. In another area, a review identified significant progress to collectively understand the real nature of criminal exploitation locally. It also identified strengths in partnership working to engage with and support children and families affected by all forms of exploitation.

7.15 We have emphasised the critical role of schools in the safeguarding system; this was an evident strength in some of rapid reviews and LCSPRs analysed for this annual report. Schools have a pivotal role to play in protecting children of school age because they are uniquely positioned to identify concerns early and to recognise when concerns are escalating. Several rapid reviews and LCSPRs highlighted how schools can provide a safe space for children, and build beneficial relationships with their families. We support initiatives that seek to better include schools in both multi-agency practice and safeguarding partnerships, given their expertise and knowledge of children and families.

7.16 Some reviews demonstrated explicitly how immediate changes to policy and practice were being implemented. Such on-going efforts to embed learning through changes to local practice are welcome. What is less clear, however, is if, and how, such changes are leading to longer-term impact and change in the lives of children and families.

7.17 Very importantly, the new national pathfinder programme (see Chapter 2) will trial and test delivery of key government strategic commitments to improve the effectiveness of help and protection to children, giving particular and important emphasis to strengthening multi-agency leadership and practice.

8. Foundations' review of safeguarding partnerships' annual reports

8.1 This analysis involved reviewing a sample of safeguarding partners' yearly reports for the year 2022/23. The original intention was to review one report from each region, however neither Foundations nor the Panel received any yearly reports from safeguarding partners in one region. Nine reports were analysed in total. This review was light-touch, aiming to examine whether the content and quality of these reports had changed significantly since the last reporting period in 2021/22.

Key Findings

8.2 Under Working Together to Safeguard Children (HM Government, 2023) safeguarding partners are required to produce yearly reports on the activity they have undertaken in a 12-month period. These should be submitted to the Panel and Foundations. This year, only 26 reports were received out of 132, which was significantly fewer than previous years; this is of concern. The content and quality of reports continued to vary significantly, despite the Panel recently providing additional guidance to support their drafting (see Child Safeguarding Practice Review Panel guidance (CSPRP, 2022d).

8.3 Consistent with the findings from previous years, most of the reports that were analysed remained largely descriptive and had little focus on using evidence and data to demonstrate the value or rationale for initiatives, which is required under Working Together (HM Government, 2023). It was positive to see one report discussed collection and analysis of multi-agency data to support partnership working and planning.

8.4 There continued to be little information regarding the impact that safeguarding activities and interventions are having on the wellbeing and safety of children and families. Some reports, however, did acknowledge this absence and noted that future reports would address the impact of safeguarding activities more specifically once evaluation processes were embedded.

8.5 All annual reports included a section on training opportunities to upskill and support staff. Whilst it was encouraging to see several reports describe undertaking high-level evaluation of this training, most reported on attendance levels rather than on outcomes or impact for staff.

8.6 There was less information on actions taken following local or national child safeguarding practice reviews than we have seen in previous years. It is positive to see reports acknowledging a lack of progress where this is the case, and setting out the actions they are taking to overcome this, including one report highlighting an evaluation process to assess improvements and changes resulting from practice reviews.

Implications

8.7 Further work is needed to improve compliance with Working Together to ensure all safeguarding partners publish an annual report. Annual updates to Working Together are unlikely to achieve this on their own.

8.8 Foundations and the Panel had also hoped that the second full year of reporting would yield more comprehensive and higher quality reports, but too few were received to enable a robust assessment. While some areas have used feedback to improve their approaches to reporting, many of the concerns highlighted in previous years remain an ongoing issue. There is a need to support safeguarding partners to produce reports that move beyond describing approaches and activities and place a greater emphasis on the reasons and evidence behind selecting priority areas, the activities carried out and the impact these have.

How the Panel and Foundations are working together

8.9 Foundations recently published a 5-year strategy, Building the Foundations 2023-2027, which sets out how Foundations will prioritise 5 thematic priority areas to shape and improve services for children and families. The Panel and Foundations will continue to collaborate on areas of common interest. Foundations is committed to ensuring that the issues emerging from the Panel reviews are reflected in Foundations' work. This might include work to generate new evidence or synthesise the existing evidence in areas where learning from case reviews shows a lack of clarity about what best practice might involve. In addition, the Panel's forthcoming work on neglect will feed into Foundations' work to synthesise the existing evidence on neglect in 2024.

8.10 Foundations is focused on ensuring that learning from practice influences the focus of new primary research studies, and that research findings are used to inform practice and service development. Effective co-ordination between the Panel and Foundations is important for improving support for children and families.

8.11 Safeguarding partnership yearly reports are important public records required in national guidance and need to be easily accessible to families and professionals (HM Government, 2023). They should provide information about multi-agency priorities,

learning, impact, and improvement (HM Government, 2023). It is recognised that, in the context of the revised Working Together, there is a need to review expectations about safeguarding partner yearly reports, including what and how national analysis may need to be undertaken.

9. The Panel at work and future priorities

The Panel at work

9.1 The Panel plays a key role within the English child protection and safeguarding system. This chapter details how the Panel fulfilled this role during 2022.

System oversight: Maintaining oversight of the system of national and local reviews and how effectively it is operating

9.2 The Panel receives and considers all rapid reviews produced by safeguarding partners and provides feedback on the decision whether to conduct an LCSPR. This helps to promote consistency across the system. On occasions, the Panel disagrees with a safeguarding partnership's decision or considers that there is insufficient evidence in the rapid review to draw a similar conclusion. In such cases, the Panel engages with local safeguarding partners to understand and help with their decision-making processes. The ultimate decision on whether to conduct an LCSPR rests, however, with the safeguarding partnership. As the Panel guidance indicates, LCSPRs should be submitted to the Panel within 7 days before the date of publication so there is time to discuss the learning and recommendations. The Panel encourage early discussions where an LCSPR may attract public and/or media attention or where it contains national recommendations for the Panel.

System learning: Identifying and overseeing the review of serious child safeguarding cases which, in the Panel's view, raise issues that are complex or of national importance

9.3 The Panel does this by commissioning national reviews and thematic analyses based on trends from rapid reviews. As more LCSPRs are completed and published, the thematic analysis of learning from LCSPRs will become an increasingly important feature of our work.

9.4 Towards the end of 2021 the Panel began work on two national reviews. The first national review published in May 2022 – Child Protection in England – was initiated in the context of widespread public distress about the circumstances of the tragic deaths of Arthur Labinjo-Hughes and Star Hobson following the conclusion of their murder trials. The review focused on what happened to Arthur and Star respectively and highlighted weaknesses in information sharing and seeking, a lack of robust thinking and challenge of both parents and carers and other professionals, and a failure to trigger statutory multi-agency child protection processes. These practice problems were sadly very familiar and so the Panel sought to triangulate its analysis of what happened

to Arthur and Star with a wider evidence base, including that from local rapid reviews and LCSPRs. The report made 8 national recommendations; Government responded to these in Children's social care: stable homes, built on love (Department for Education, 2023e). These sought to address some of the fault lines in the design of English safeguarding practice; these include the need for sharper focus at a national and local level on how agencies work together to protect children from significant harm so that strategic and operational arrangements are clear and well understood.

9.5 The second national review – Safeguarding children with disabilities and complex health needs in residential settings – was published in 2 parts. The first, published in October 2022, sought to make sense of how and why a significant number of children with disabilities and complex needs came to suffer very serious abuse and neglect while living in three privately provided residential settings run by the Hesley Group in Doncaster. The second, published in April 2023, draws on the learning from what happened at the residential home to focus on the national changes that must be secured to help this group of children thrive and keep safe in the future. Government's response to the recommendations was published in December 2023 (Department for Education, 2023j).

9.6 The voices of children with complex health needs and disabilities are often overlooked in both practice and policy. Many of the children living in Hesley provision were non-verbal and it was important that their voices and perspectives were represented in the reviews. To do this, the Panel drew on both information from Doncaster Council and South Yorkshire Police and from roundtable discussions with many stakeholders, including representatives of parent-led organisations to help ensure that the voice and experiences of children were at the heart of the review.

System leadership: Identifying improvements to practice and protecting children from harm

9.7 The Panel disseminates evidence, insights and learning from local and national reviews through an extensive communication and stakeholder engagement programme. Stakeholder discussions were a critical element of both recent national reviews (Child Protection in England and Safeguarding Children with Disabilities and Complex Health Needs). The findings of both these national reviews were then shared with stakeholders through a series of webinars for safeguarding partners and other stakeholders. Nationally, the Panel works in a cross-governmental context with officials and ministers from different government departments and has attended the Cross Ministerial Child Protection Group to discuss Panel work. We also engage routinely with a range of other national stakeholders, including Children and Family Court Advisory and Support Service (CAFCASS), Office for Standards in Education, Children's Services and Skills (Ofsted), Association of Directors of Childrens Services (ADCS), National Police Chiefs Council (NPCC), the Independent Office for Police

Conduct (IOPC), Children's Commissioner, Royal College of Paediatrics and Child Health (RCPCH), the National Network of Designated Healthcare Professionals (NNDHP) and a range of national voluntary sector organisations including the NSPCC to contribute to and influence the development of research and policy on child safeguarding practice.

Progress on the Panel's commitments as set out in the Annual Report 2021

9.8 The Panel's mission is to help protect children from abuse, neglect, and harm through excellent safeguarding practice; supporting the safeguarding system to achieve this. The 2021 Annual Report identified 4 important priorities for its work in 2022. These are outlined below.

Promote child centred practice, ensuring the voices and perspectives of children, families and communities inform child protection and safeguarding practice and policy	The Panel review rapid reviews and LCSPRs which should be rooted in children's lived experiences. Central to this is considering whether children and young people's voices and lived experiences have been considered by professionals who have worked with them as well as within the rapid review and LCSPR processes themselves. The Panels seeks to promote and encourage the voices, experiences, and perspectives of children to beat the heart of its work. Within national reviews, the Panel will involve children and families where possible. Where this may not be possible because of on-going criminal investigations or other reasons, the Panel endeavour to involve children and young people in a different way through existing forums. Finally, in 2022, the Panel updated guidance and published good practice examples of rapid reviews which highlight the centrality of foregrounding children's, and their families', voices in reviews.
Tackle perennial and complex barriers to effective practice	The Panel have delivered two national reviews, described above: 1) Child Protection in England 2) Safeguarding Children with Disabilities and Complex Needs in Residential Settings (published in two parts) The Panel have also produced and published further thematic analysis and guidance on:

	• Multi-Agency Safeguarding and Domestic Abuse (Published in 2022)
	• Bruising in Non-Mobile Infants (Published in 2022) The Panel have commissioned a new national review about intrafamilial child sexual abuse, which will be delivered in 2024. The Panel have worked with government to ensure improvements to the child protection system are made in a timely manner and fit the reality of working in the multi-agency system. For example, the Panel contributed to Government responses to the 2 national reviews: Stable homes, built on love strategy, the Children's Social Care National Framework and to the revised Working Together to Safeguard Children, including the national multi-agency child protection standards and multi-agency safeguarding arrangements. The Panel have also been working with IOPC on a new information sharing protocol.
Use evidence and data to drive system improvement and learning through high quality reviews	The Panel have entered into a new partnership with the Vulnerability Knowledge and Practice Programme to establish a Data Insights team to provide robust quantitative and qualitative analysis of rapid reviews and LCSPRs in order to support the identification of learning for safeguarding partners to use as they develop their systems and processes. The Panel have initiated 2 thematic projects, one on neglect and the other on race, racism and ethnicity; work will be progressed on both projects in 2024. The Panel seek to inform and influence the development of government policy and its implementation, for example, as expressed in Stable homes, built on love. This includes the Panel's delivery, with partners, of a new learning support offer to local safeguarding partnerships.

Encourage system learning and sharing of best practice to promote the behaviours and culture necessary for excellent child protection and safeguarding practice	The Panel have hosted a series of regional roundtables with safeguarding partnerships. In 2022, the Panel hosted 11 virtual roundtables with safeguarding partners in each region of England. Over 450 delegates from 142 local partnerships attended, with representatives from health, local authority and policing. A range of safeguarding practice issues were covered in these roundtables, including: • maximising and improving learning from reviews • evaluating their impact • ethnicity, race and culture • what is meant by 'serious harm' • the impact of poverty and the cost of living on families and on safeguarding practice. • mental health and suicide The Panel continue to publish regular newsletters for safeguarding partners, providing information about the work of the Panel, relevant national developments and LCSPRs that have been published. The Panel have also published practice briefings for safeguarding partners on a range of issues (for example, domestic abuse) to communicate learning from thematic analyses.

Priorities and the 2023/24 work plan

9.9 The Panel have set out key priorities in their Business Plan for the 2023/24 period. These priorities and some of the on-going activities to achieve these priorities are set out below.

Core Panel work

9.10 The core work of the Panel will continue, which includes:

- Oversight of the system of local and national reviews, by considering every serious incident of harm/abuse/neglect notified to the Panel.
- Increasing the quality and depth of data analysis of rapid reviews and local reviews over time through our established partnership with the Vulnerability

Knowledge and Practice Programme 'Data Insights team', as part of our 'weathervane' role in the system.

- Continue to increase and develop engagement with safeguarding partners in a range of different ways including webinars, roundtables, meetings and through correspondence to support problem-solving, sharing best practice and disseminate learning. This includes an enhanced offer of engagement through our partnership with the Vulnerability Knowledge and Practice Programme who will assist and extend our reach and value to safeguarding partnerships, government, and other stakeholders.
- Commission an independent evaluation of the Panel's impact on the system.

Gather, analyse and disseminate intelligence about the multi-agency system

9.11 A key priority of the Panel is to gather, analyse and disseminate intelligence about the multi-agency system and share this with local safeguarding partners. It also undertakes a quality assurance role through the provision of feedback to local safeguarding partners about the quality of rapid reviews and LCSPRs. Specifically:

- The Panel will continue to work with the VKPP Data Insights Team to support the Panel in monitoring trends from reviews. The VKPP will also begin to provide capacity to draw out and disseminate learning for the system.
- Supported by the VKPP Data Insights Team, the Panel has produced this 2022/2023 Annual Report and will support production of subsequent reports.
- The Panel held its first national conference in June 2023, bringing together 350 safeguarding partners and sector experts from across the country.

Tackle perennial and complex barriers to effective safeguarding practice

9.12 The Panel's oversight of safeguarding practice reviews provides insight into issues that are of national importance. The on-going and future work of the Panel aligned to this priority includes the following:

- The Panel have commissioned two new national reviews: one on the safeguarding issues raised by the death of Baby M in 2023; and a thematic national review on child sexual abuse in the family environment, the focus of which will be on the conditions for effective multi-agency practice across the system. This review will take account of the latest report on the national analysis of police-recorded child sexual abuse and exploitation crimes report published by the Vulnerability Knowledge and Practice Programme (VKPP, 2024).

- The Panel are undertaking key thematic analyses on:
  - neglect, which will consider the extent and nature of serious incidents notified to the Panel where neglect is the primary cause of death and serious harm and incidents where neglect is a contributory factor to death and serious harm
  - race, culture and racism, identifying key themes in professionals' perceptions of needs and risks of different groups of Black and Asian children and families and service responses – it will also consider how different groups of Black and Asian children are 'seen and heard' and identify examples of positive practice.

Maximise the impact of learning from safeguarding reviews, enabling robust and joined up leadership nationally and locally

9.13 We will continue to strengthen our relationships with safeguarding partners across England to support and maximise the impact of learning from safeguarding reviews, enabling robust and joined up leadership nationally and locally. This will include in 2024 delivering a new learning support project through a collaborative partnership involving Research in Practice, the University of East Anglia and the Vulnerability Knowledge and Practice Programme to local safeguarding partnerships areas to strengthen practice learning through the delivery of effective LCSPRs.

9.14 The Panel has continued to develop the Pool of Reviewers who help it undertake national reviews. The Pool was most recently refreshed in August 2023 and currently includes 21 suppliers, ranging from data specialists and universities to experts who have worked in Children's Services.

Work independently to challenge contemporary practice and policy where evidence indicates that this is inhibiting effective access to help and protection of different groups of children from abuse and neglect

9.15 The Panel will continue to use its unique position in the system to influence important stakeholders on key messaging and learning about the multi-agency child protection system. This includes contributing to the design and delivery of the Families First for Children (FFC) pathfinder pilot programme, announced in February 2023 as part of the government's children's social care implementation strategy Children's social care: stable homes, built on love.

9.16 The Panel will continue to work regularly with key national bodies including inspectorates, the charitable sector, the Children's Commissioner, and many national professional organisations and others to share national learning and influence national policy and practice development.

Reflecting on and monitoring our own work

9.17 The Panel has been in existence for over 5 years. How we work continues to evolve and change, in response to changing needs, membership and circumstances, as well feedback and learning about how we might need to change aspects of how we work. The multi-disciplinary nature of the Panel is one of its intrinsic strengths, but it is equally critical that we continuously interrogate how our individual and collective biases and assumptions shape our work, for example in terms of how services help and protect Black children and children with disabilities. In these respects, the Panel's work mirrors challenges experienced by local safeguarding partners.

9.18 We need to take stock of the impact of the Panel's work. In 2024, therefore, we will be commissioning work to evaluate the Panel's impact. We look forward to involving stakeholders in this review, inviting critical challenge and analysis of where we do make a difference to practice and where we might work differently.

10. Conclusion

10.1 As discussed in Chapter 2, the timing of this report takes place in an ever-evolving environment that affects safeguarding practice. This includes a changing policy landscape, some increased complexity of needs in families, and major workforce recruitment and retention pressures. This annual report has considered a range of practice themes to support safeguarding partnerships and other stakeholders to reflect on issues in practice which are affecting our collective ability to help and protect children.

10.2 The following questions have been formulated to help safeguarding partnerships consider how best to embed learning, and to sustain changes and improvements in their local safeguarding system.

- **Culture**
  - Is there an understanding across multi agency leadership of the different contexts, responsibilities, and operating challenges across partners?
  - How do you role model behaviours that create an inclusive culture where diversity is understood, and multi-agency and multi-disciplinary working is celebrated?
  - How do you role model a culture of professional challenge, including questioning one another's assumptions, and be seen to resolve difference of opinion in a restorative and respectful way?
- **Clear partnership intent**
  - Has a clear and balanced partnership intent developed from assessment of local need and threat, in addition to shared understanding of each other's contexts, responsibilities and challenges?
  - Is there clear evidence that responsibilities are shared and equal?
  - Is there the right support, challenge, and accountability across agencies so that everyone can be more ambitious in achieving the goal of seeing families thrive, and understand the impact of their services?
- **Strategy to delivery**
  - Does the strategy get informed by and contribute to front line practice?
  - Is there evidence of a data strategy and investment in joint analysis and audit, which supports delivery of the strategy to be effectively reviewed, issues and good practice to be escalated and monitoring for new threats?

- **Assessing effectiveness**
  - How do you know what you are doing is effective?
  - How are independent scrutiny, audit, local and national practice reviews, and inspections being used to assess impact of the arrangements to the benefit of children and families, as well as the strength of local leadership?
  - How is the voice of children and families experiencing the multi-agency systems utilised in the design and delivery of local arrangements? This should include information sharing and decision making, organising referral pathways, delivering services and support.
- **Getting upstream**
  - How do you use learning to focus efforts on prevention and early intervention, providing help and support to meet the needs of children as soon as problems emerge?
  - How does this feed into wider analytical assessments to inform service commissioning?
  - How do you use horizon scanning as a partnership and respond based on this? This can include consideration of thresholds documents, design of referral pathways and services.
- **Workforce**
  - How do you work together across agency on shared issues related to the workforce?
  - How is multi-agency training commissioned, delivered and monitored for impact? How does learning from reviews/audits/inspections feed into training priorities? How do you undertake any multi-agency and interagency audits?
  - Do you have a recruitment and retention strategy? How do you develop strategic leads and ensure leadership maturity? How do you support recruitment using safe working practices?
  - How do you ensure capacity for workforce to engage in peer-learning and knowledge-exchange, peer-audit, group/individual supervision, and observation and promote staff welfare?

10.3 We want this report to be useful to all stakeholders in highlighting a range of practice and systems challenges, but also share some of the good practice we are seeing by the many committed strategic leaders, senior and middle managers and those delivering direct practice to children and young people.

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Appendix A – Glossary

Term	Acronym	Definition
Absolute low income	-	An individual is in absolute low income if their household income is below 60% of the median in a base year, adjusted for inflation, usually 2010/11 (Francis-Devine, 2023).
Adultification	-	The practice of authority figures being less protective of and more punitive towards children of racial minorities.
Black magic	-	A branch of magic which is believed to involve death, destruction, manipulation and spells. A belief that magic is used for evil purposes by invoking the power of an evil spirit or devil (Slough Safeguarding Partnership, 2023).
Care leaver	-	A care leaver is a person who has been in Local Authority care (e.g. residential or foster care) for a period of at least 13 weeks or more, or periods amounting in total to 13 weeks or more, since they were age 14, and ending after age 16.
Child criminal exploitation	CCE	Where an individual or group takes advantage of a power imbalance to coerce, control, manipulate or deceive someone under 18 into any criminal activity in exchange for something the victim needs or wants, and/or for financial gain or other advantage of the perpetrator and/or through violence or the threat of violence.
Child and Adolescent Mental Health Services	CAMHS	Specialised health services that assess and treat young people with emotional, behavioural or mental health difficulties.

Term	Acronym	Definition
Child in need	CIN	Section 17 of the Children's Act 1989 defines a child in need as: "he/she is unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision for him/her of services by a Local Authority; his/her health or development is likely to be significantly impaired, or further impaired without the provision for him/her of such services; he/she is disabled."
Child Protection Conference	-	A multi-agency meeting between a child's parents/carers, the child (if appropriate) and practitioners involved in the child's care, organised by the local authority. The aim of the conference is to look at all the relevant information and decide what steps need to be taken to ensure the safety and welfare of the child.
Child protection plan	CPP	A child protection plan is a written record detailing the actions and responsibilities of services and parents to protect those children identified to have been seriously harmed or to be at risk of significant harm.
Child Safeguarding Practice Review Panel (The Panel)	CSPRP	An independent panel set up under the Children and Social Work Act 2017, working with the Department for Education. The Panel commissions reviews of serious child safeguarding cases with a focus on improving learning, professional practice and outcomes for children.
Child Sexual Exploitation	CSE	A form of child sexual abuse where an individual or group takes advantage of a power imbalance to coerce, manipulate or deceive someone under the age of 18 into sexual activity in exchange for something the victim needs or wants, and/or for financial advantage or increased status of the perpetrator. The victim may have been sexually exploited even if the sexual activity appears consensual. Child sexual exploitation does not always involve physical contact; it can also occur using technology.

Term	Acronym	Definition
Children's Social Care	CSC	Departments within local authorities who are concerned with all forms of personal care and other practical assistance for children and young people who need extra support.
Contextual Safeguarding	-	Contextual Safeguarding is an approach to understanding, and responding to, young people's experiences of significant harm beyond their families. It recognises that the different relationships that young people form in their neighbourhoods, schools and online can feature violence and abuse.
Domestic Abuse, Stalking, Harassment and Honour-Based Violence Assessment Tool	DASH	A multi-agency risk assessment tool used by practitioners to identify risks following domestic abuse, particularly to identify those victims who are at high risk of harm.
Department for Education	DfE	A ministerial department responsible for children's services and education including early years, schools, higher and further education policy, apprenticeships and wider skills in England.
Early help	EH	Provides early support and intervention to families to improve outcomes for children or to prevent escalating need or risk.
Elective home education	EHE	Where parents have decided to educate their children at home or in some other way instead of them attending school full-time.
Extrafamilial harm	-	Risks to the welfare of children that arise within the community or peer group, including sexual and criminal exploitation. A key element of extrafamilial harm is that in general, harm does not arise from the home environment; parents may not be aware that their child is at risk or may be struggling to protect their child and the family from harm against exploiters.
General Practitioner	GP	A doctor working within primary care.

Term	Acronym	Definition
Hate crime	-	Any criminal offence which is perceived by the victim or any other person, to be motivated by hostility or prejudice based on a person's race or perceived race; religion or perceived religion; sexual orientation or perceived sexual orientation; disability or perceived disability and any crime motivated by hostility or prejudice against a person who is transgender or perceived to be transgender.
Information Technology	IT	Electronic systems and infrastructure used for storing, retrieving, and sending information.
Index child	-	The child who is the focus of a rapid review and/or LCSPR because of a serious incident.
Intrafamilial harm	-	Harm that occurs within a family environment. Perpetrators may or may not be related to the child and a key consideration is whether the abuser is seen as a family member or carer from the child's point of view.
Intersectionality	-	The concept of intersectionality describes the ways in which systems of inequality based on gender, race, ethnicity, sexual orientation, gender identity, disability, class and other forms of discrimination 'intersect' to create unique dynamics and effects.
Joint Targeted Area Inspection	JTAI	A joint multi-agency inspection conducted by Ofsted, the Care Quality Commission (CQC) and HM Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) into themed areas of child protection and safeguarding.
Lesbian, Gay, Bisexual, Transgender and Queer (or Questioning)	LGBTQ+	Used to represent non-heterosexual identities and orientations.
Local Child Safeguarding Practice Review	LCSPR	An in-depth multi-agency review in response to a serious child safeguarding incident to identify system learning and practice changes to improve the safeguarding of children and young people.
Looked after children	LAC	A child who has been in the care of their local authority for more than 24 hours.

Term	Acronym	Definition
Multi-agency risk assessment conference	MARAC	A meeting involving statutory safeguarding partnerships and other services to share information and discuss those at the highest risk of domestic abuse to create a coordinated action plan.
Minoritise	-	To make (a person or group) subordinate in status to a more dominant group, its members or another person.
National Referral Mechanism	NRM	The National Referral Mechanism allows safeguarding statutory partners to refer individuals who they believe are at risk of criminal exploitation, modern day slavery and trafficking, creating a framework for identifying victims and providing them with appropriate support.
National Society for the Prevention of Cruelty to Children	NSPCC	A UK child protection charity.
Not in education, employment or training	NEET	A young person who is no longer in the education system and who is not working or being trained for work.
Rapid review	RR	A multi-agency review of a serious incident where a child has died or been seriously harmed and where abuse and/or neglect is suspected to identify, collate and reflect on the facts of the case with the aim of establishing if any immediate safeguarding action is needed and identifying the potential for practice learning.
Return home interviews	-	A return home interview is an in-depth conversation with a child who has gone missing from home and has been reported to the police. It is an opportunity to learn about the child's life, including any intrafamilial or extrafamilial risk to harm.
Safeguarding Partners	-	Local safeguarding arrangements are led by three statutory safeguarding partners: the local authority, the police and the integrated care board.

Term	Acronym	Definition
Serious incident notification	SIN	A notification is submitted to the Child Safeguarding Practice Review Panel by a local authority when a child has died or been seriously harmed, and abuse or neglect is suspected. SINs included within this report are ones which have led to a rapid review.
Structural racism	-	Systematic discrimination and disadvantages faced by racial and ethnic minority groups as a product of a system in which policies, practices, cultural representations, and other norms perpetuate racial inequity by reinforcing a cycle of discrimination and exclusion (European Network Against Racism, 2023).
Working Together	-	Statutory guidance on inter-agency working to safeguard and promote the welfare of children. The latest version was published in 2023.

Appendix B – Cause of death categories

Category of death	Definition
Accident/injury	Where a death has occurred from an accident or accidental injury.
Child homicide – intrafamilial	Deaths where a child is killed by someone within the family, other than a parent or primary caregiver. This would include homicide perpetrated by siblings, grandparents, aunts, uncles, cousins etc.
Child homicide – extrafamilial	Deaths where a child is killed by someone other than a family member, primary caregiver or other adult with caring responsibilities.
Overt child homicide by primary caregiver	Deaths where a child is killed by a parent or primary caregiver using overtly violent means, or with no attempt to conceal the homicide, and where there appears to have been some intent to kill the child.
Covert Child Homicide by primary caregiver	Deaths where a child is killed by a parent or primary caregiver using less overtly violent means, and with some apparent attempt to conceal the fact of homicide with some apparent intent to kill the child.
Death following self-harm	Deaths where the child has deliberately harmed themselves but there is no indication that they intended to complete suicide.
Death from extreme neglect	Deaths where the child dies directly because of severe neglect/deprivation of their needs with evidence that this has been deliberate, persistent, or extreme.
Fabricated/induced illness	Deaths where a parent or caregiver has exaggerated or deliberately caused symptoms of illness resulting in the child's death. This includes a parent or caregiver inducing illness which led to the death, or a where a child dies from medical intervention in response to a fabrication or induction of illness and there is evidence of behaviours carried out to convince professionals of an illness where there is no objective evidence of a medical condition.
Fatal assault – intrafamilial	Deaths following physical assaults (non-accidental injuries) where the suspected perpetrator is a primary caregiver or adult with caring responsibilities and there was no clear intent to kill the child.

Category of death	Definition
Fatal assault – extrafamilial	Deaths following physical assaults (non-accidental injuries) where the suspected perpetrator is someone other than a family member, primary caregiver or adult with caring responsibilities and there was no clear intent to kill the child.
Medical cause	Deaths resulting from medical causes.
Risk taking behaviour	Deaths resulting from the child engaging in dangerous activities including drug related deaths, or accidents from risk-taking behaviour where there is no evidence that the child intended to complete suicide.
Severe, persistent child cruelty	Deaths where a child dies directly because of a physical assault or neglect and there is evidence of previous severe and persistent child cruelty. This includes deaths where a post-mortem examination reveals previous inflicted injuries or long-standing neglect.
Suicide	Deaths where there is evidence that the child has completed suicide including cases still under investigation, but circumstances suggest suicide.
Unclear	Deaths where the cause remains completely unclear and with no obvious pointers to any of the other categories.
Unexplained SUDI/SUDC	Deaths viewed as sudden unexpected death in infancy (SUDI) or childhood (SUDC) which were not anticipated as a significant possibility 24 hours before the death, or there was a similarly unexpected collapse leading to or triggering the events with no specific cause of death found (whether natural or external).

Appendix C – Cause of serious harm categories

Category of serious harm	Definition
Accident/injury	Serious harm arising from accidents or injuries.
Attempted suicide	Cases of injury or serious harm resulting only from the child's attempt to complete suicide.
Child criminal exploitation	Where an individual or group takes advantage of a power imbalance to coerce, control, manipulate or deceive someone under 18 into any criminal activity in exchange for something the victim needs or wants, and/or for financial gain or other advantage of the perpetrator and/or through violence or the threat of violence.
Child sexual abuse – intrafamilial	All forms of sexual abuse where this was the predominant form of maltreatment or the incident which led to notification and where the suspected perpetrator is an immediate or wider family member, primary caregiver or adult with caring responsibilities for the child in the home.
Child sexual abuse – extrafamilial	All forms of sexual abuse where this was the predominant form of maltreatment or the incident which led to the notification and where the suspected perpetrator is a person other than a family member, primary caregiver or other adult with caring responsibilities for the child.
Child sexual exploitation	A form of child sexual abuse where an individual or group takes advantage of a power imbalance to coerce, manipulate or deceive someone under the age of 18 into sexual activity in exchange for something the victim needs or wants, and/or for financial advantage or increased status of the perpetrator. This can involve violence or the threat of violence.
Emotional abuse	All forms of emotional abuse where this has been the predominant form of abuse, or the incident which led to recognition or notification of harm.

Category of serious harm	Definition
Fabricated/ induced Illness	Serious harm caused when parent or caregiver has exaggerated or deliberately caused symptoms of illness in the child resulting in serious harm. This includes a parent or caregiver inducing illness which led to serious harm, or a child is seriously harmed from medical intervention in response to a fabrication or induction of illness and there is evidence of behaviours carried out to convince professionals of an illness where there's no objective evidence of a medical condition.
Medical cause	Serious harm arising from medical causes.
Non-fatal Assaults – extrafamilial	Serious harm from severe physical assaults (non-accidental injuries) which has been caused by someone other than a family member, primary caregiver or other adult with caring responsibilities for the child within the home. Encompasses child-on-child violence by children external to the family.
Non-fatal assaults – intrafamilial	Serious harm from severe physical assaults (non-accidental injuries) where the suspected perpetrator is a primary caregiver, an adult with caring responsibilities for the child at the time of harm or another child within the family (e.g. sibling, cousin).
Non-fatal neglect	Serious harm because of severe or chronic deprivation of the child's needs with evidence that this has been deliberate, persistent or extreme.
Other non-fatal incident	Any other non-fatal serious incident which does not clearly fit one of the other categories.
Risk taking behaviour	Serious harm due to the child engaging in dangerous activities including serious harm following drug related incidents, or accidents from risk-taking behaviour where there is no evidence that the child intended to harm themselves.
Self-harm	Where the child deliberately harmed themselves but there is no indication they intended to complete suicide.
Severe, persistent child cruelty	Serious harm because of a physical assault, emotional abuse or neglect, and there is evidence of previous severe and persistent child cruelty. Encompasses serious harm where medical examination reveals evidence of previous inflicted injuries (e.g. healing fractures) or long-standing neglect in addition to the primary cause of serious harm.
Unclear	Other non-fatal serious harm where the nature of maltreatment is not clear.

Appendix D – Systems framework for understanding effective risk assessment and decision-making

Understanding effective risk assessment and decision-making

A Systems Framework

Systems and processes

(including key decision points on continuum of care pathway, sharing information, use of specialist assessment)

- The importance of robust multi-agency arrangements for contact, referral and assessment, including high quality inter-agency discussion.
- Thresholds or levels of need to be understood by practitioners across all agencies and consistently applied.

Practice and practice knowledge

(incorporating the Panel's 'Key practice themes to make a difference')

- The importance of relational practice models that promote purposeful direct work with children and families.
- Practitioners apply critical thinking to their work, reframing their understanding of risk in the light of changing circumstances.
- Practitioners have the requisite professional knowledge to identify risk in particular safeguarding contexts such as risk outside the home. A key gap in professional knowledge relates to cultural competence as absence of cultural competence can lead to inaccurate assessments and decision making.

Wider service context

(including workforce development, commissioning strategy, funding, match of resources to priorities, impact of socio-economic factors)

- The impact of wider socio-economic factors such as poverty and inadequate accommodation.
- The provision of early help services to support families in helping themselves.
- Workforce development – effective recruitment and retention of staff, with appropriate caseloads.
- Using data effectively to respond to changing patterns of demand and need.

Leadership and culture

(including vision and values, partnership relationships, multi-agency working, quality of supervision, management oversight, challenge between professionals, timely and appropriate escalation)

- Supervision is crucial to risk assessment and relies on effective leadership to create the learning culture within which effective supervision can thrive.
- Leaders promote wider values to underpin the relationships between professionals across the partnership, and in the work with families.

Appendix E – LCSPR sample and qualitative analysis method

Dates used for sample selection

In selecting the LCSPR sample for analysis we used the ‘completion date’ of the review to determine inclusion according to the January 2022 to March 2023 time period. For 'completion date' we have used the date recorded on the final LCSPR report. Where this was not available, we used the date included in the file name for the report, or the date the LCSPR was considered by the Panel following submission. We have chosen 'completion date' rather than 'publication date' for the following reasons:

- the actual publication date may not be known
- the LCSPR may not have been published so there would be no publication date
- there can sometimes be a substantial delay between the review being completed and publication actually taking place
- the point at which the review is completed is the point at which all the relevant learning has been identified by the safeguarding partnership and should be the point from which the learning is shared more widely

This approach is different to the approach for selecting rapid reviews for the same period. Rapid review analysis uses the 'incident date' for inclusion in the data set. This is not an appropriate method for LCSPR inclusion however, as the incident date for LCSPRs is often many months or even years before the LCSPR is produced and the learning is identified, compared to a much shorter gap between an incident and the production of a rapid review. Furthermore, the rapid reviews look at incidents that happened during a specific period, whereas LCSPRs focus on the learning that has been identified and shared by safeguarding partners during a specific period.

To help us select the 40 cases, we first captured key information from all 144 LCSPRs that were completed between January 2022 and March 2023. Copies of the LCSPRs were provided by the Department of Education and included all those considered by the Panel during the period January 2022 to September 2023. These were filtered to remove cases with a completion date prior to 2022 or post-March 2023. It is worth noting that some cases completed January to March 2023 may have been considered by the Panel after September 2023, but could not be included here as analysis took place during October 2023. However, this is likely to be a very small number of cases.

Key information captured from the LCSPRs included socio-demographic characteristics (age group, sex, disability, ethnicity etc) and specific features of cases that would help us to explore the six practice themes, such as whether the case involved domestic abuse, or risks outside the home. Much of this information was available from serious incident notification and rapid review logs for the cases. The research team checked this information for accuracy and filled in any omissions.

Case selection

In selecting the 40 LCSPRs to use for in-depth analysis relating to the practice themes, 10 cases were chosen that featured race, ethnicity or culture; 10 cases that involved babies under 12 months old; 10 cases that involved domestic abuse; and 10 cases that featured risks outside of the home. Cases were filtered according to these practice criteria and were then purposively selected to ensure a range across sex, disability and harm type. Table 6 provides a breakdown of the sample of 40 by key characteristics (cases with unknown characteristics have been removed from the analysis).

Table 6: Characteristics of the sample of 40 LCSPRs

Characteristic	Category	Count	Percentage
Age group			
	Under 1	14	35%
	1 to 5	5	13%
	6 to 10	4	10%
	11 to 15	9	23%
	16 to 17	8	20%
	Total	**40**	**100%**
Sex			
	Female	20	50%
	Male	20	50%
	Total	**40**	**100%**
Disability			
	Yes	8	23%
	No	27	77%
	Total	**35**	**100%**

Characteristic	Category	Count	Percentage
	Unknown	5	
Ethnicity			
	White British	20	53%
	Other white background	2	5%
	Asian or Asian British	4	11%
	Black or Black British	5	13%
	Mixed ethnicity	5	13%
	Other ethnic group	2	5%
	Total	**38**	**100%**
	Unknown	2	
Harm category			
	Death	19	48%
	Serious Harm	21	53%
	Total	**40**	**100%**

Analysis

We analysed 10 LCSPRs for each of the following practice themes: race, ethnicity and culture; responding to the vulnerability of babies; domestic abuse and harm to children; and risks outside the home. Due to their cross-cutting relevance, all 40 cases were analysed to explore themes of critical thinking and professional challenge, and whole family approach to risk assessment and support. Given the cross-cutting relevance and importance of race, ethnicity and culture, in addition to undertaking in-depth analysis of 10 LCSPRs we also noted any specific issues related to this theme that featured in the other 30 cases in the LCSPR sample.

In addition to the qualitative analysis of the LCSPRs, the rapid review database was also used to identify those reviews where the practice themes featured, and particular system strengths and challenges were identified. This high-level content was then also analysed and compared with the findings from the LCSPR analysis to check if themes and findings were consistent.

Content analysis was used to code the LCSPRs. Content analysis is a way of interpreting text through the systematic classification process of coding and identifying themes or patterns (Hsieh and Shannon, 2005). We used a 'directed approach' to content analysis, drawing on themes and sub-themes identified in our previous reports, to help deepen our understanding and capture recent learning, while also identifying new and emerging themes.

Data was analysed in Excel by members of the analysis team and quality assured by managers. An iterative and constant process of discussion and reflection between all those conducting the analysis was used to ensure consistency of understanding and 'sense check' emerging findings. Regular discussions with Panel members throughout the analysis supported this sense checking and meaning making process.

Limitations

While rapid reviews and LCSPR reports provide a source of rich data on multi-agency practice in child safeguarding, there are some limitations that must be acknowledged. First, these reviews represent serious cases of death and harm that are identified as such and accepted by safeguarding partnerships. They do not, therefore, represent all cases of death and harm of children, nor do they represent the full picture of multi-agency response to safeguarding needs.

Second, our analysis was necessarily dictated by the types of cases chosen by safeguarding partners for review. The balance of these reviews tends towards intrafamilial cases, although we have purposefully explored risks outside the home as one of the six practice themes to make a difference. They also tend towards cases where there is scope for new learning to emerge and therefore do not represent the whole system.

Third, the time it takes between commencing an LCSPR and publication can be lengthy, by which time practice may have moved on or been addressed through new guidance or training. It is worth noting that as many of the incidents within the LCSPRs predate 2022, they took place before the learning from recent reports was published and so reviews may not necessarily always reflect current practice. However, we also know that new directions in, or guidance on, practice may not be absorbed equally across partnerships. We believe, therefore, that much of the learning we are seeing continues to be relevant – even if some areas have successfully addressed some of the issues. In recognition of the 'learning lag', we work closely with stakeholders to ensure the messaging and learning points within our reports remain current.

Fourth, the quality and quantity of information about the role of agencies in these cases is variable within reviews. Sometimes reviewers primarily describe agency responses, with little analysis or reporting of the reasons why the practice occurred. In part, we know that reviewers may themselves be limited by the quantity and quality of information they are

able to access when conducting reviews. Without good detail about the explanations for errors or missed opportunities, we are less able to target messages for practice at the 'right level'.

Fifth, relevant characteristics of cases, like ethnicity and gender, are often missing from reviews which limits our ability to examine the lived experiences of children (see Chapter 4 for a discussion on the quality of reviews).

Sixth and finally, reviews take a 'deficit' model approach which means they seek out what went wrong, rather than what went right. Reviewers do praise practitioners for good practice on occasion, but specific detail about the features of good practice is often weakly described, limiting our ability to articulate what 'good' looks like.