

Annual Report 2020

Patterns in practice, key messages
and 2021 work programme

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Evidence base

(All data is for the period 1 January 2020 – 31 December 2020)

1. Primary Sources

- **Serious Incident Notifications** are made by local authorities where a child has died or is seriously harmed, and abuse or neglect is known or suspected.
- **Rapid reviews** for each notification. A rapid review report is commissioned by the Panel from the relevant local safeguarding partners. The purpose of the rapid review is to gather the facts of the case, consider the potential for learning and decide whether or not to undertake a Local Child Safeguarding Practice Review (LCSPR).
- **Local Child Safeguarding Practice Reviews (LCSPR)** are commissioned by safeguarding partners in response to a serious child safeguarding incident in their area. These reviews are undertaken to provide learning to avoid similar incidents occurring in the future. There is an expectation that these reviews are published.
- **30 Serious Case Reviews published in 2020.**

2. National reviews and thematic analysis commissioned by the Panel

3. Commissioned reports:

- Qualitative analysis of all LCSPRs and 25% sample of rapid reviews received during the year (UEA/ University of Birmingham)
- Analysis of safeguarding partners yearly reports (What Works Centre Children's Social Care)

1. Foreword

This second annual report from the Child Safeguarding Practice Review Panel provides analysis and reflection on English safeguarding practice during what has been an indescribably hard time for children and families. It has also been a period of unprecedented test and challenge for all those entrusted with safeguarding and protecting children from harm.

The Panel seeks to provide a window on contemporary safeguarding practice, offering insight into how well national and local systems and organisations help and protect children. It is clear to me, as the new chair, that the Panel is establishing a clear identity and role within the still relatively new national architecture for safeguarding. Nonetheless, we know that there is much more to do to enhance the impact and effectiveness of local and national learning. We hope that this report will contribute to that. Over the next 12 months, the Panel will be looking to strengthen its reach and relationships with all its stakeholders, including safeguarding partnerships and across government.

This report has three important messages. Firstly, the Panel's analysis of practice brings into sharp relief once again the importance of using our very best resources and skills to give a real and strong voice (and influence) to children. We fail too often to grasp and make sense of the intrinsically unique identities and life experiences of children. 'Reading between the lines' of what children and families say and communicate (as well as what they do not say) involves time, imagination and the most proficient of relational skills. We all have responsibility for creating the conditions in which the talents and resources of practitioners can prioritise understanding what life is like for children.

Our second core message concerns the urgency of addressing what might be described as stubborn and perennial problems in multi-agency child protection practice. Issues such as weak information sharing, communication and risk assessment have, over decades, impeded our ability to protect children and to help families. The English child protection system has generally proved to be extremely adaptive and resilient, but despite the best of intentions (and very many inquiries), professional systems and cultures have not successfully tackled some of these deep-seated challenges.

As Atul Gawande said in his Reith Lecture (2014):

'It is uncomfortable looking inside our fallibility. We have a fear of looking'¹

We need to question and challenge ourselves when we talk about issues such as poor 'risk assessment', 'disguised compliance' and weak 'professional curiosity', thinking carefully what we mean and why these issues are coming about. The Panel is prioritising addressing some of these perennial problems in its 2021 to 2022 work programme. Working with stakeholders, including safeguarding partners, we want to consider how we might work differently to address these issues to better protect children.

Our final message is about the need to understand and evaluate robustly the impact of learning from rapid reviews as well as local and national practice reviews. There is increasing evidence that the safeguarding 'system' is developing its capacity to reflect and learn. Although the Panel still sees examples of old ways of thinking, we have discerned real and evidenced shifts in the way that reviews are moving from an emphasis on 'reporting about' to 'inquiring into and learning from'. This is positive, but it also means that together we need to develop ways of systematically evaluating the effectiveness and impact of learning.

¹ Atul Gawande: The Reith Lectures 2014 – The Future of Medicine. Lecture 1: Why do Doctors Fail?

I hope that this annual report is valuable to safeguarding leaders and practitioners in reflecting on the quality and impact of practice. The past year has been without precedent in terms of the scale and volume of challenges for the safeguarding system; that individuals have responded with extraordinary ingenuity and commitment to help and protect children is beyond doubt. It has perhaps never been more important therefore to take stock and learn in order to influence the quality and outcome of children and families' experiences of safeguarding practice. Looking ahead, the Panel will continue to enhance and diversify the ways it supports the very best standards of safeguarding practice, including through our contribution to the national Care Review, and to other policy and practice developments.

Annie Hudson

Chair of Child Safeguarding Practice Review Panel

2. Introduction

1. This is the Panel's second annual report, covering our work from 1 January 2020 to 31 December 2020. It sets out our views about how effectively the system of national and local reviews is operating. With the unique challenges presented by the COVID-19 pandemic, we recognise that this was a year like no other. In implementing new multi-agency safeguarding arrangements, safeguarding partners have shown resilience, creativity and adaptability in striving to maintain effective support for vulnerable children and families. As the tripartite leadership of safeguarding partnerships develops, it will be important for them to evidence local assurance, learning and the overall impact of the partnership in improving child safeguarding.
2. Our oversight of national and local reviews gives us a unique insight into patterns of practice in child safeguarding, illuminated by the Panel's national reviews and wider analysis of local reviews. From our analysis we have highlighted six key practice themes to make a difference in reducing serious harm and preventing child deaths caused by abuse or neglect. These themes are not new, but they are amongst the most urgent, and also the most difficult. Underpinning all of them is the importance of effective leadership and culture – dimensions which are too often left unexplored in the case reviews that we see. We expect these six themes to be a focus for shared learning with safeguarding partnerships, and nationally, to improve the safeguarding system.

Six key practice themes to make a difference

1. Understanding what the child's daily life is like
2. Working with families where their engagement is reluctant and sporadic
3. Critical thinking and challenge
4. Responding to changing risk and need
5. Sharing information in a timely and appropriate way
6. Organisational leadership and culture for good outcomes

Section 5 of our report provides an extended outline of each theme, with learning drawn from reviews and case illustrations.²

3. The replacement of Serious Case Reviews by a system of rapid reviews and Local Child Safeguarding Practice Reviews (LCSPRs) is intended to enable safeguarding partnerships to identify and disseminate swifter real-time learning from serious safeguarding incidents. A key challenge for the Panel, working collaboratively with safeguarding partnerships, is to improve the quality and consistency of these arrangements. At present, the quality of rapid reviews is too variable. Effective rapid reviews identify immediate learning, how and when that learning can be disseminated and set out a clear rationale for whether to initiate an LCSPR. Unfortunately, we see too high a proportion of rapid reviews where there is insufficient analysis to inform learning or aspects for review through an LCSPR.

² The case illustrations are derived from individual case reviews. They are designed to highlight key aspects of learning related to the six practice themes.

4. LCSPRs provide an opportunity to explore the learning and practice themes from rapid reviews in more depth. The Panel is concerned that many of the LCSPRs that it has seen to date are structured and read like Serious Case Reviews, with insufficient focus on new learning. As well as improving the quality of LCSPRs, the Panel is keen to see a significant increase in the number of reviews that are completed and published. Without publication of LCSPRs, learning is not shared and a key principle of the learning system is weakened.
5. To address the key issues in this report, the Panel will further develop its system leadership role in making the safeguarding system more effective and more efficient. We want to ensure that we are able to distil and disseminate learning from rapid reviews and LCSPRs in more meaningful ways to influence policy and practice. Critical to that role is the development of our work in a cross-governmental context and with all stakeholders, both to contribute to and influence the way in which research and policy in child safeguarding is developed. We will also increase our communication and engagement with stakeholder bodies and safeguarding partnerships.
 - A Panel member will be linked to safeguarding partners in each of the nine English regions to support discussions on issues of mutual interest.
 - We will gather, analyse and share data and learning quarterly from rapid reviews and LCSPRs, so that valuable insights and practice themes can be disseminated more quickly to support improvements locally and nationally.
 - We have commissioned an external organisation to undertake research and intelligence gathering with safeguarding partners and stakeholders to enable us to better understand the impact of the Panel's work and what can be done to improve communication and shared learning.
6. Our mission, working with others, is to develop and embed a learning culture where agencies at every level are honest when things go wrong, where partners are properly held to account without scapegoating, where there is time and determination to reflect and learn, and where that learning translates quickly into policy and practice. We invite you to engage with the learning in this report and have set out some reflective questions for taking forward improvements together.

Reflective questions for local leaders

1. **How do safeguarding partners model personal leadership of, and accountability for, the dissemination and embedding of learning in their local area?**
2. **How do you know that the new system of learning is making an impact? What are the key barriers? How can the Panel work with you to address them?**
3. **How can we make better use of national reviews to support learning and improvement in your area?**
4. **How can we work together to give practitioners a sense of confidence, support and progress in addressing the stubborn challenges in child safeguarding?**

3. Challenges of the COVID-19 pandemic

7. The COVID-19 pandemic has had a profound impact on our lives for an extended period. The effects for individual children and young people, families and the wider community are likely to be with us for some time. Like all public services, agencies working in child safeguarding had to adapt quickly to continue to meet statutory requirements, maintain support for vulnerable children and families, and do so in ways that ensured COVID-safe practice.

Evidence from our analysis of Serious Incident Notifications and rapid reviews is that the COVID-19 outbreak continues to present a situational risk for vulnerable children and families, with the potential to exacerbate pre-existing safeguarding risks and bring about new ones. Notifications to the Panel in the period April to September 2020 were 27% higher than the same period in 2019, although the increase in notifications was less significant when compared to the 2018 data.

8. A thematic analysis commissioned by the Panel identified the key impacts of COVID-19 on vulnerable children and families, using an analytical model derived from the evidence in published commentary and stakeholder research.³ Further details can be read in our Practice Briefing 'Supporting Vulnerable Children and Families During COVID-19'. We identified four key factors which, in combination, increased vulnerability and risk:

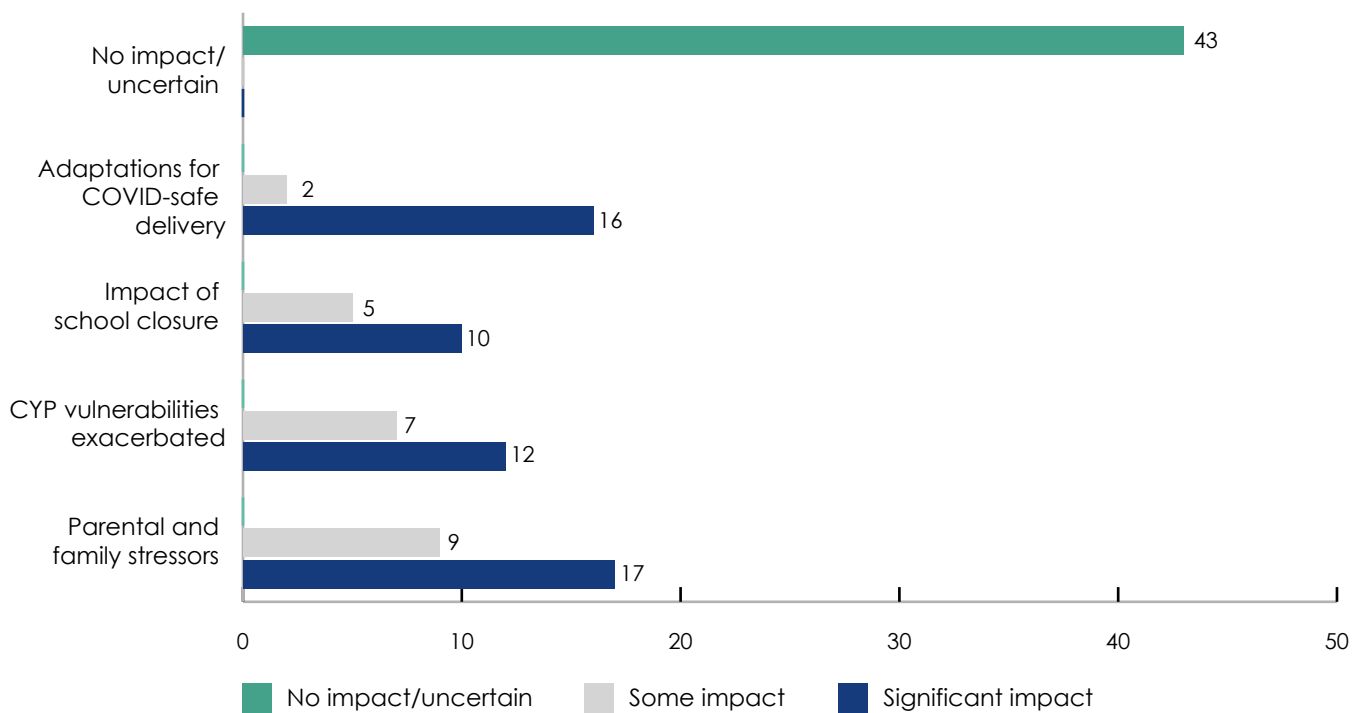
- Parental and family stressors
- Exacerbated vulnerabilities for children and young people
- Impact of school closures: Identification of, contact with, and support for vulnerable children and young people
- Impact of adaptations for COVID-safe practice

The impact of the individual factors varied according to the age of the children and the nature of the safeguarding risk. The relative impact of these factors is shown in graphs 1 and 2 below. Parental and family stressors were a strong factor in incidents involving non-accidental injury (NAI) and neglect and sudden unexpected death in infancy (SUDI). School closures were a more significant factor in incidents involving adolescents.

³ The sample (43 cases) comprised all rapid reviews that had come to the Panel between March and September 2020 which had cited COVID-19 as a factor in the serious incident or wider case background. For comparative purposes, a control group comprising a random sample of 40 rapid reviews received by the Panel over the same time period was audited.

Graph 1

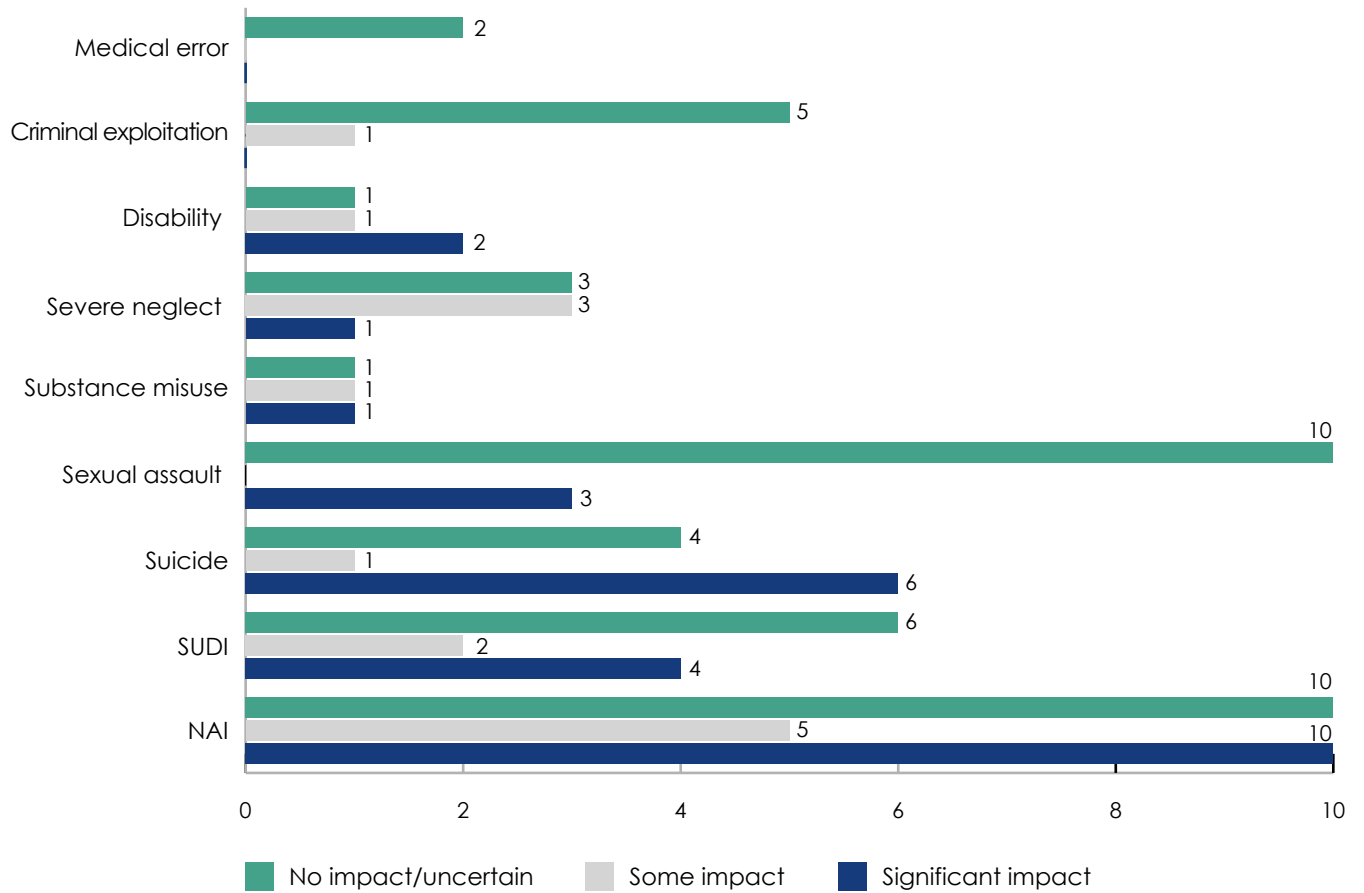
Relative impact of COVID-19 factors in sample of cases audited by the panel



9. The increase in serious safeguarding incidents where COVID-19 was a factor was most marked in those categories that account for the highest proportion of notifications to the Panel: NAI in children under 1, SUDI and suicide.

Graph 2

Impact of COVID-19 factors by case theme



Our analysis highlighted important learning for safeguarding partners and relevant agencies to apply in any subsequent period of lockdown or school closure during the on-going pandemic.

Practitioner working

10. There were good examples of safeguarding partnerships taking the learning from rapid reviews to make immediate changes in COVID-19 protocols for practitioners. Local authorities, working with safeguarding partners, established clear frameworks for risk assessment, identifying and sharing information about vulnerable children.

In one local area, the safeguarding partners were committed to twice-weekly conference video calls to identify risk, share information, monitor and scrutinise contingency plans to continue 'business as usual' as safely as possible.

A safeguarding partnership serving an extensive sub-region of local authorities developed a communications campaign in local communities that services were continuing to respond to all reports of child abuse despite the lockdown.

Parental and family stressors

11. These were major factors across the full range of cases involving COVID-19. Increasing domestic violence and mental health concerns were key features across the rapid reviews. The lack of contact with extended family members during lockdown meant the loss of a key protective factor in some cases. In others, family dynamics changed where a new partner joined the household to avoid lockdown contact restrictions. Reviews highlighted pressures and tensions as a result of disrupted routines and overcrowding.

Harm to babies under 12 months old

12. Babies under 12 months old continue to be the most prevalent group notified, and there were a high proportion of cases involving non-accidental injury and sudden unexpected infant death. In these cases, parental and family stressors were the most significant factor in escalating risk. In some of the cases, face-to-face visits had been replaced with telephone or video contact. A key point of learning was that adaptations for COVID-safe practice in lockdown should maintain at least one face-to-face visit from a midwife and health visitor to families with new-borns.

Young people's mental health

13. Being away from the support of friends, trusted adults and school appeared to have a particular impact on children and young people's mental health and was evident in all cases of suicide. Reviews highlighted incidents of self-harm, exposure to sexual abuse and online bullying.

School closures

14. Rapid reviews provided mixed evidence of the impact of local authorities and schools in identifying and supporting vulnerable children and young people. There were some good examples where schools had maintained contact, promoted study support and other activities, and adapted their approach in line with evolving national guidance and expectations. However, many vulnerable children who were entitled to attend school were kept at home by parents because of their fears about COVID-19 infection. This meant children lost structure and routine where parents' capacity to provide home schooling was limited. Additionally, children at home full-time added pressure for parents, particularly for carers with disabled children. School was not available as a source of support or as a trusted environment for children to disclose concerns, and as a result, some

vulnerable children remained 'below the radar'. This reinforced the crucial role that schools play in child safeguarding and the need to strive to keep schools open in any future lockdown period, if at all possible.

Adaptations for COVID-safe practice

- 15.** Adapting practice was an important factor across the full range of cases involving COVID-19. Typically, this related to circumstances where face-to-face home visits or booked appointments were replaced by telephone contacts or virtual visits. Where these worked well, practitioners were able to observe children, assess the home environment and use focused questions to assess changing risk and need. In their yearly reports, safeguarding partnerships identified opportunities to take forward successful adaptations for COVID-safe practice into more blended arrangements for working with families through a combination of visits and remote support, in accordance with assessment of risk. Effective work with children and families during the lockdown period emphasised the importance and impact of direct help and support for vulnerable families from practitioners.

Anticipated increases in referrals and demand for post-pandemic

- 16.** Safeguarding partners anticipated a surge in referrals at the end of the lockdown period in the autumn of 2020 and made plans to respond to emerging needs and address gaps.

Further analysis of the impact of the COVID-19 pandemic

- 17.** In our 2021 work programme, we will build on the findings of our first COVID-19 thematic analysis. We will identify and review cases notified in more recent lockdown periods to see whether the features and themes identified provide intelligence about the nature of incidents in a time of restriction and/or lockdown.

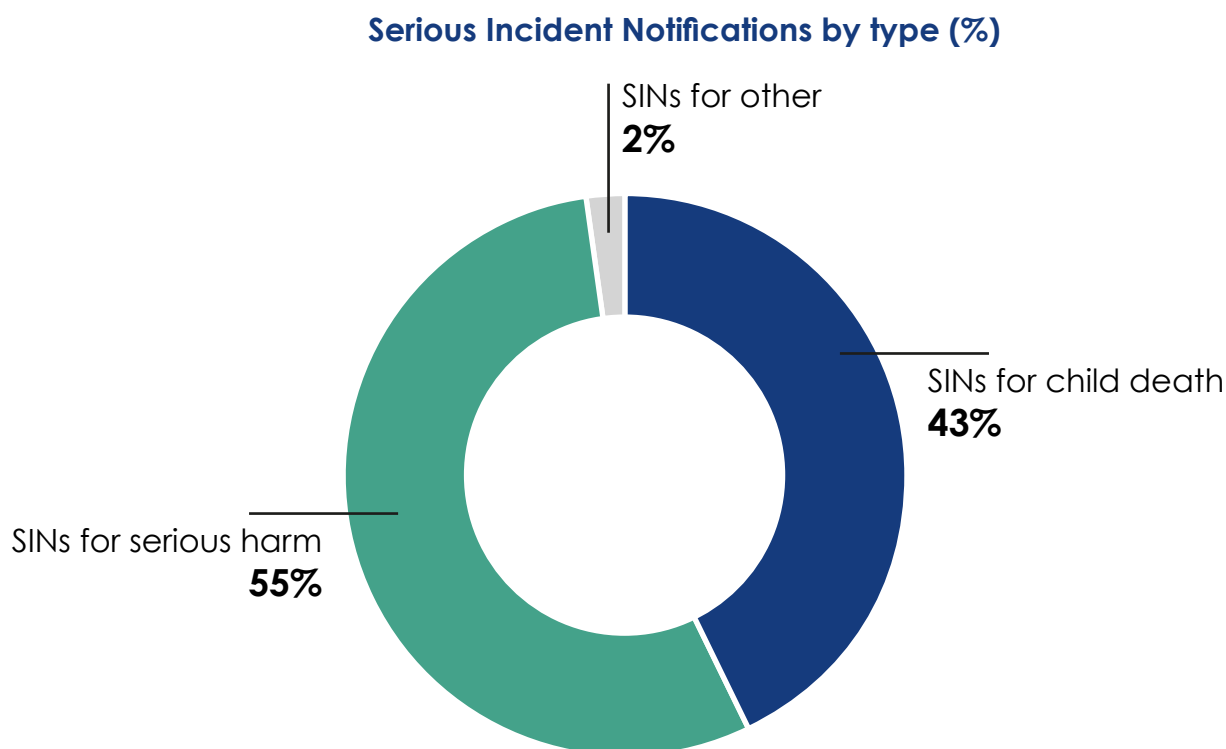
4. 'A window on the system'

18. The Panel has a unique insight into the challenges faced by safeguarding partners through its oversight of the notification of serious safeguarding incidents and local reviews. We have drawn together the information from Serious Incident Notifications and rapid reviews, illuminated by learning from the Panel's national reviews and wider analysis of local reviews. All data cited in this section, including graphs, charts and tables, covers serious safeguarding incidents occurring between the period 1 January 2020 to 31 December 2020.

Serious Incident Notifications (SINs)

19. The Panel received notification of 482 serious incidents which occurred between 1 January and 31 December 2020, relating to 514 children. Of those 482 notifications, 206 were in relation to child deaths and 267 related to serious harm. Nine notifications were for other issues, including six where the young person was a perpetrator of harm, two in which the young person was subject to criminal exploitation and one where the young person had engaged in risk taking or violent behaviour.

Chart 1



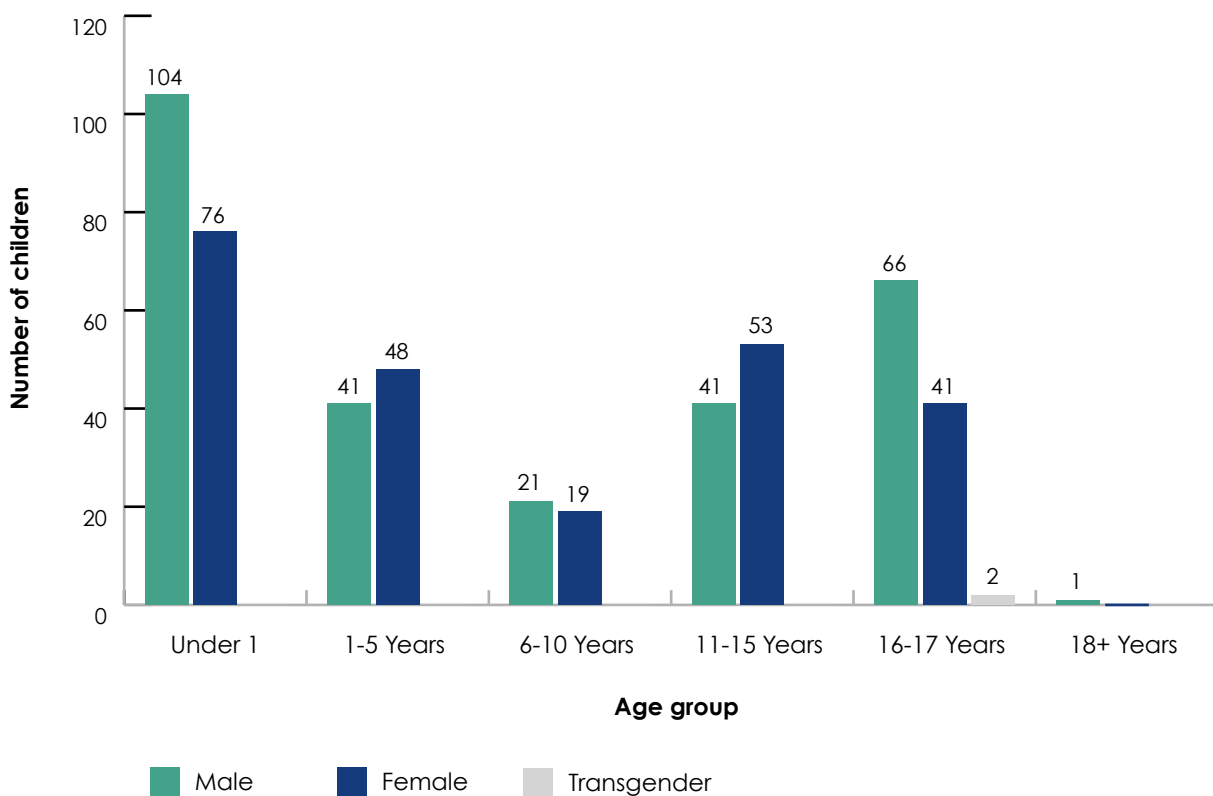
The concentration of serious safeguarding incidents was greatest (39% of all notified incidents) for children living in the 20% most deprived areas of England (based on the Index of Multiple Deprivation). Just 5% of all notified incidents were for children living in the 20% least deprived areas.

Age and gender

20. Of the 514 children involved in the incidents, 274 (53%) were male and 238 (46%) were female. There were two transgender young people. The age distribution showed a predominance of infants under the age of one (35%) and a second peak in 15-17 year olds (30%).

Graph 3

Serious Incident Notifications by age and gender



Gender identity and transgender young people: Co-ordination of support and access to services

Our analysis of local reviews suggests that, although this is not a new consideration, working with transgender young people and consideration of how young people wish to identify may be new for some practitioners. Our thematic analysis of notifications relating to children who had committed suicide noted that gender identity issues had emerged as a significant factor in seven of the incidents in the sample.

Ethnicity

21. Table 1 below shows that the majority (69%) of children were of White British ethnicity. However, compared to the ethnic breakdown of the 0-17 year-old population in the 2011 census, there was a higher proportion of ethnic minority children among the incidents notified to the Panel. This was particularly marked among black teenagers and among mixed ethnicity children of all age groups. Those from Asian ethnic groups were under-represented in all age groups compared to the general population. There are several cases where the ethnicity was not recorded in the serious incident notification.

Table 1

Ethnic Group	Number	Percentage (where recorded)	Percentage of 0-17 year olds in 2011 census
Asian or Asian British	34	7.4	9.7
Black or Black British	38	8.2	4.7
Mixed	62	13.4	5.0
White British	320	69.3	79.3
Any other ethnic group	8	1.7	1.2
Not recorded	52	-	-
Total	514	-	-

In a number of rapid reviews, the ethnicity of the family does not feature in the characteristics described, even when the information has been included in the original serious incident notification to the Panel. There is a concern that issues relating to ethnicity and cultural competence are not being addressed if they are not recorded.

The importance of these issues will be reinforced by the Panel through guidance. We will ensure that the scoping of national reviews and thematic analyses includes explicit consideration of issues relating to ethnicity and cultural competence.

Cultural competence

Culturally competent practice places children's well-being and protection within their cultural context. Absence of cultural competence can lead to inaccurate assessments and decision making. Our evidence from practice reviews suggests that the impact of culture on parenting is not always overtly considered or evidenced. Practitioners need to be supported through training and supervision to feel confident in addressing issues of culture in the families that they work with, and to be clearer about the potential impact of cultural assumptions and norms in relation to safeguarding risks.

Learning from reviews highlights the importance that practitioners recognise their own cultural identity and its impact on others. Practitioners need support and training to identify and respond to racism when they encounter it.

Child deaths

22. Of the 206 fatal incidents, 36 (17%) were caused by maltreatment within the family, 17 (8%) were extra-familial assaults or homicide, 63 (31%) were sudden unexpected deaths in infancy (SUDI) and 42 (20%) were suicides. A further 20 (9.7%) were related to, but not directly caused by maltreatment. Domestic abuse featured in 41% of fatal cases and neglect was a feature in 35%. SUDI formed the most common category of fatal cases and was the focus of the Panel's second national thematic review, published in July 2020.

Table 2

Category of death	Number	Percentage of all fatal cases
Overt filicide	10	4.8
Covert filicide	3	1.5
Fatal physical abuse	22	10.7
Severe, persistent child cruelty	1	0.5
Extreme neglect/deprivational abuse	0	0.0
Extra-familial child homicide	2	1.0
Extra-familial fatal assaults	15	7.3
Sudden Unexpected Death in Infancy (SUDI)	63	30.6
Suicide	42	20.3
Other deaths related to maltreatment, of which:	20	9.7
Accident	8	
Medical	1	
Risk-taking behaviour	5	
Poisoning	1	
Other	5	
Not maltreatment related	15	7.3
Not clear	13	6.3
Total	206	100.00

National review of SUDI in families where the children are considered at risk of harm

- Families living within a context of recognised background risks (such as, deprivation and overcrowding, domestic violence or poor mental health) are at heightened risk of losing a baby to SUDI.
- All those working with families need to recognise this and work together, this is not just an issue for midwives and health visitors.
- We need a flexible and tailored approach to prevention that is responsive to the reality of people's lives.
- The best local arrangements for promoting safer sleeping involve a range of professionals as part of a relationship-based programme of support, embedded in wider initiatives to promote infant safety, health and well-being.

The review has identified a number of issues that have helped inform the development of a 'prevent and protect' practice model. We believe this model, if embedded in practice, has the potential to improve the way safeguarding partners work with families to reduce the risks of SUDI, and beyond that, to address a much wider range of risks to their children's health, safety and development.

For a copy of the full report click here.

Suicide

- 23.** Suicide in young people remains an important issue, accounting for 20% of all incidents. Young people's feelings of isolation during the COVID-19 lockdown were a contributory factor in a number of incidents. More generally, it was not always clear whether a suicide was linked to suspected abuse or neglect. Often there was not a single trigger event.

Preventing self-harm and suicide

In 2020 the Panel commissioned a thematic analysis of Serious Incident Notifications where the child had committed suicide. A sample of 98 notifications was examined. Our analysis concluded:

- The themes in the lives of the 98 children in our sample reflected the common themes identified in the University of Manchester's 2017 report, 'Suicide by Children and Young People'. These included: abuse or neglect from others, bereavement, relationship issues, substance misuse, children missing from home and bullying in an educational setting. A fifth of all the cases involved children who were, or had previously been, involved with Children's Services, including looked after children and care leavers.
- Practitioners can contribute to suicide prevention through greater awareness of the range of factors that may add to risk, and of the 'final straw' stresses that can lead to suicide. This requires agencies to work together and jointly unravel the complex interplay of the risk factors, recognising that clear evidence of harm and stress may not always be visible. Practice that takes account of contextual risk issues (for example, peer-to-peer sexual abuse or debt slavery) is required across all safeguarding agencies.

The Panel expects further learning and insight from the review of suicides that is being undertaken through the National Child Mortality Database.

Serious harm

24. Non-fatal physical abuse (for example unexplained bruises or fractures) was the most common form of non-fatal serious harm (22%) followed by child sexual abuse (10%) and young people involved in risk-taking or violent behaviour, or as perpetrators of harm (11%).

Table 3

Category of serious harm (The data below includes the nine serious incidents notified to the Panel as 'other')	Number	Percentage of all non-fatal cases
Non-fatal physical abuse	105	38.0
Non-fatal neglect	33	12.0
Emotional abuse	5	1.8
Child sexual abuse – intra-familial	28	10.1
Child sexual abuse – extra-familial	20	7.2
Child sexual exploitation	5	1.8
Criminal exploitation	4	1.4
Young person perpetrator	7	2.5
Other risk taking/violent behaviour	51	18.5
Other non-fatal incidents	18	6.5
Total	276	100.00

Neglect

25. Neglect was the primary form of serious harm to children in 7% of incidents. However, it was an underlying feature of 35% of fatal incidents and 34% of non-fatal incidents. For example, neglect was recognised as a feature in 40% of all deaths related to (but not directly caused by) maltreatment, including 45% of all SUDI cases. Our thematic analyses of rapid reviews involving non-accidental injury and suicide identified neglect as a key aspect of harm or early childhood experiences.

Recognising and responding to neglect

Learning from practice reviews indicates that the recognition of cumulative neglect and its impact continues to be a key challenge for practitioners, with incidents of neglect too often treated in isolation. The use of evidence-based risk tools and assessments of parenting capacity can support professionals in their assessment of neglect, ensuring a common framework and shared understanding between practitioners. Often, practitioners are working with families where neglect features in combination with other risk factors such as parental substance misuse and domestic abuse. In these circumstances it is important not to focus on a single issue (e.g. lack of suitable housing). Professionals can become desensitised to the impact of adverse socio-economic circumstances. In working with families where neglect is a presenting concern there needs to be specific understanding and analysis of adverse socio-economic circumstances on parenting capacity and the daily life of the child. These issues warrant greater consideration as part of the learning in rapid reviews and LCSPRs.

Domestic abuse

26. Domestic abuse was a feature of 42.6% of incidents involving serious harm. This predominantly involved the father as a perpetrator and mother as a victim (74%). Other patterns, including the mother as perpetrator, both parents as perpetrators and young person to adult abuse in the household, were recognised.
27. Important insights into the impact of domestic abuse and the response to it are provided in the Ministry of Justice report, '**Assessing Risk of Harm to Children and Parents in Private Law Children Cases**' published in June 2020. In response to a recommendation in that report, in 2021 the Panel will be commissioning a practice-based review of incidents involving domestic abuse.

Impact of domestic abuse

Domestic abuse is a key feature in the case sample for the Panel's national thematic review of Non-Accidental Injury (NAI) in children under one, which is still underway. It was found that Domestic Abuse, Stalking and Harassment (DASH) assessments and other risk tools tended to focus more on risks to adults rather than children. In some cases, there was insufficient co-ordination between Multi-Agency Risk Assessment Conference (MARAC) processes and children in need planning.

There was a high degree of variation in the types of programmes commissioned by local authorities and safeguarding partnerships to address domestic abuse. Responses to incidents of domestic abuse were most effective where there was a robust analysis of risks to the victim and support for them; swift action to ensure safety of the children and provide on-going support in recognition of emotional abuse; and purposeful work with the perpetrator, followed up to monitor the extent of sustained engagement and positive outcomes. Domestic Violence Prevention Orders or Notices (DVPO/DVPN) had limited impact where they were not accompanied by a robust support plan.

There is currently no national system to track males who have previously had domestic abuse/violence convictions and later move in with other partners.

Child criminal exploitation

- 28.** There were 51 incidents in which young people were involved in risk-taking or violent behaviour. Of the 51 incidents, 37 (75%) had evidence of criminal exploitation, gang violence or county lines activity as background factors, although they were not the primary cause of serious harm. Within the total of 51 incidents, 15 involved non-fatal self-harm, four were specifically linked to criminal exploitation and there were seven in which a young person was a perpetrator of harm to others.
- 29.** Child criminal exploitation (CCE) was the focus of the Panel's first national thematic review, published in March 2020. The learning from the review is shown below. We are now following this up with a 'Phase 2' examination of CCE cases received by the Panel since the report was published.

National review: Safeguarding adolescents at risk of criminal exploitation

- Known risk factors around adolescent vulnerability do not always act as predictors of risk of criminal exploitation.
- Moving children away from the local area is not an effective long-term solution to protect them from the reach of criminal gangs.
- Exclusion from school can escalate the risk of manipulation by criminal networks.
- Relationship-based practice and making use of the 'reachable moment', such as arrest, school exclusion and physical injury, are critical for this group of children.

For a full copy of the report click [here](#).

- 30.** Peer-on-peer abuse was an identifiable feature in thirteen reviews related to adolescent harm. This comprised a range of behaviours: peer bullying, peer sexual abuse, physical abuse (including knife and gun violence) and exploitation. Rapid reviews covered incidents where the child was a victim, a perpetrator, or sometimes both.

Case characteristics

31. Table 4 shows the main case characteristics from the 482 notifications to the Panel.

Table 4

Case characteristic	Death N (%)	Serious harm N (%)	Other N	Total N (%)
Parent characteristics				
Parental alcohol misuse	57 (27.7)	30 (11.2)	0	87 (18.0)
Parental drug misuse	59 (28.6)	54 (20.2)	1	114 (23.7)
Parental adverse childhood experiences	25 (12.1)	33 (12.4)	0	58 (12.0)
Parent care leaver	7 (3.4)	12 (4.5)	0	19 (3.9)
Parental criminal record	41 (19.9)	45 (16.9)	1	87 (18.0)
Parental mental ill-health	62 (30.1)	73 (27.3)	0	135 (28.0)
Parental learning difficulty	6 (2.9)	8 (3.0)	0	14 (2.9)
Family characteristics				
Parental separation	97 (47.1)	122 (45.7)	4	223 (46.3)
Domestic abuse	85 (41.3)	114 (42.6)	2	201 (41.7)
Elective home education	3 (1.5)	12 (4.5)	0	15 (3.3)
Child characteristics				
Disability	21 (10.2)	15 (5.6)	0	36 (7.5)
Mental ill-health of child	31 (15.0)	43 (16.1)	3	77 (16.0)

Mental health

32. Maternal mental ill-health was a feature in 24% of incidents (114) and paternal mental ill-health in 7% (32). Parental drug or alcohol abuse was common, involving both mothers and fathers, while a parental criminal record was more common in fathers or father figures than mothers. Parental separation was a feature in nearly half of all incidents. There was a lot of overlap between the case characteristics, indicating the possibility of cumulative harm in many of these families.

The combination of domestic violence and substance misuse appears particularly strong, accounting for 24% of all incidents. In contrast, parental mental ill-health or substance misuse in the absence of any reported domestic violence was less common. It is important that these factors are not treated in a deterministic way in assessing risk in families. They need to be considered in the specific circumstances of a household including parental age, quality of housing, employment status and identity factors, such as ethnicity.

33. Parental mental ill-health was a feature in 20% of all incidents. This was a particularly significant factor with fathers/male carers in cases of non-accidental injury. Maternal mental health was a key factor in cases relating to filicide and neglect.
34. In 16% of the incidents, the child had experienced mental ill-health. A common theme found in local reviews and various thematic analyses by the Panel is the need for accessible mental health support to address early childhood trauma and reduce risk-taking behaviours. A frequent finding was that the eligibility criteria for Child and Adolescent Mental Health Services (CAMHS) support limited flexibility and responsiveness to meet children and young people's mental health needs. These issues have taken on greater significance as a result of the evident concerns about children and young people's mental health and emotional well-being during the COVID-19 pandemic.

Adult mental health

In the fieldwork for the national review of NAI we found many fathers had a variety of mental health issues whether ADHD, anger management, anxiety or depression. Therapeutic work is rarely offered or accepted, either when young through CAMHS, or by adult mental health provision when the focus is not on their role as parents but as adults. The issue of emotional dysregulation needs better understanding across the system.

Learning from local reviews suggests that maternal mental health concerns were sometimes not recognised and factored into the overall assessment of risk. This was particularly so in cases of neglect where the impact of poor mental health was reflected in mood swings, lack of recognition of children's needs and difficulty in keeping routines. There was a training need for non-mental health practitioners to understand the mental health risks in parenting capacity, and pathways to access mental health support. Tired parents on medication for mental ill health sometimes exacerbated the risk of falling asleep with an infant in unsafe circumstances.

Looked-After Children

- 35.** Twenty child deaths and 43 incidents of serious harm involved looked after children. The incidents notified to the Panel varied in range from non-accidental injury of babies through to gang-related criminal exploitation. The Panel has analysed notifications relating to looked-after children to identify common themes and areas for further development.

Looked-After Children (LAC)

From a sample of 89 cases where LAC had died or suffered serious harm, the analysis focused on 48 incidents where children became looked after as a result of abuse or neglect. Key findings were that:

- children were coming into care in adolescence having experienced long-term parental abuse and neglect, with significant trauma
- where adolescent children came into care owing to previous involvement in gang-related activities or criminal exploitation, these continued once in the care system
- historic trauma experienced by these children led to high incidence of risk-taking behaviour as perpetrators or victims, and self-harming behaviour
- high levels of placement breakdown occurred as a result, with children placed in emergency unregulated placements. Mental health and other support were disrupted

These findings highlighted the importance of commissioning and sufficiency of high quality residential and foster placements for LAC displaying high risk and challenging behaviours.

Elective home education

- 36.** There were 15 incidents involving children who were reported to be electively home educated. Three of these children died, two through suicide and one through risk-taking behaviour. The non-fatal serious harm incidents included neglect, emotional abuse, and intra-familial child sexual abuse. Often these children were 'invisible' as they were not in school and not visited at home – they did not have the additional protection that school provides.

Secure establishments

- 37.** There were seven incidents involving children in secure establishments, the Panel reviewed them together to see if there are learning themes or whether to undertake a national review. The safety, welfare and care of the children needs to be the primary focus. Too often, security takes priority to the detriment of the wellbeing of often vulnerable and troubled children. Whilst not all the incidents will result in an LCSPR, there is valuable learning for the Youth Custody Service, safeguarding partners and leaders of these units. We would encourage safeguarding partners to share lessons with others providing for children in these settings.

Service involvement

38. Table 5 below outlines the service involvement in cases notified to the Panel.

Table 5

Service involvement	Death N (%)	Serious harm N (%)	Other N	Total N (%)
Child previously known to CSC	128 (62.1)	177 (66.3)	6	311 (64.5)
Information but no referral	4	10	0	14
Referral but no assessment	13	16	0	29
Initial assessment	23	13	0	36
CAF	14	11	0	25
Child in Need	32	33	0	65
CP plan	21	49	3	73
Looked after	20	43	3	66
Other	1	2	0	3
Court orders	28 (13.6)	55 (20.6)	3	86 (17.8)
Care order	12	29	2	43
Section 20 accommodation	7	16	0	23
Other	9	10	1	20
Child not resident at home	47 (22.8)	65 (24.3)	3	115 (23.9)
Living with relatives	12	17	0	29
In foster care	7	15	1	23
Residential children's home	2	14	1	17
Semi-independent unit	7	4	0	11
Other	19	15	1	35

39. In more than 60% of the incidents, the child protection system had previously identified the children as vulnerable. Despite that identification, the system was unable to prevent their death or serious harm. In our annual report in 2018-19, we highlighted the importance of effective risk management. Practice learning from national and local reviews in 2020 shows continuing weaknesses in risk assessment and decision-making, often the result of agencies not sharing information. It is a perennial theme of very many historical inquiries about children who have died. The Panel will be commissioning a thematic review of risk assessment and decision-making in its 2021 programme.

5. Six key practice themes to make a difference

40. We recognise that the challenge of child safeguarding, often in circumstances which are unpredictable, requires practitioners to engage with some vulnerable and often traumatised families. We ask them to get close to those families, to build relationships, and to use those relationships to bring about change. It is clear that safeguarding partners and relevant agencies are striving to promote practice that secures good outcomes.
41. Our lens is through the serious child safeguarding incidents notified to us, and the subsequent rapid reviews and LCSPRs that follow. We have identified six key practice themes to make a difference in reducing serious harm and preventing child deaths caused by abuse or neglect. Underpinning all of them is the importance of effective leadership and culture – dimensions which too often are left unexplored in the case reviews that we see. We expect these six themes to be a focus for shared learning with safeguarding partnerships, and nationally, to improve the safeguarding system. As part of that shared learning, we will also create opportunities to hear about and disseminate the many successful interventions that are the result of informed, intelligent and authoritative work by practitioners across partner agencies.

Theme 1 – Understanding what the child’s daily life is like

Understanding what a child sees, hears, thinks and experiences on a daily basis, and the way this impacts on their development and welfare, is central to protective safeguarding work. The complexity of situations in vulnerable families can lead to a particular focus on parental needs, which can get in the way of professionals understanding risks faced by the children. It is essential to explore the child’s experience of living with neglect, domestic violence, and substance misusing parents and to understand how these harms impact on their safety, health and overall development. The child’s views should inform analysis and assessment so that intervention is appropriate to address key concerns and needs.

Key Learning from case reviews

- It is important for practitioners to build a trusting and respectful relationship with the child, which goes beyond listening and recording the child’s views, to critically reflect on what the child is trying to communicate through their behaviour, interaction with others and physical presentation.
- Look to ascertain children’s views in a variety of ways, using structured tools to support the process.
- Recognise that challenging or help-seeking behaviour may well reflect harm and distress.
- Be aware of and challenge circumstances where children seek to minimise potential risks of harm and show reluctance to accept support.



Case study: Read between the lines

Child B had been in a kinship care placement for four years when she disclosed that she had been sexually abused by her male carer. Practitioners had found her chatty and engaged in their regular LAC and health assessments, both of which included direct statements from her. Professionals from all agencies accepted the child’s views, often expressed in front of her carers, without further exploration. Child B contributed to the review following the case and spoke of how changes in her presentation, behaviour and eating were not recognised as distress signals.

Theme 2 – Working with families where their engagement is reluctant and sporadic

Reviews often refer to 'lack of engagement' by vulnerable families, citing patterns of missed appointments, cancelled home visits, and offers of support not taken up. This is sometimes characterised as 'disguised compliance' or 'resistance'. It is important to understand the underlying issues giving rise to reluctant or sporadic engagement, particularly where professionals are 'working with consent'.

Key learning from case reviews

- Relationship-based practice recognises the importance of effective relationships and connections between practitioners and families in creating the motivation and opportunity for change.
- An understanding of adults' own experiences is essential to addressing concerns about their lack of engagement.
- Motivational interviewing provides a strong framework to initiate difficult conversations. The model of question, affirmation, reflection and summary enables practitioners to maintain a balance between being directive, supportive and non-judgmental.
- Non-engagement may be better understood as 'closure' – a response in circumstances of unresolved adverse childhood experiences or socio-economic pressures, where individuals believe that what is happening to them is largely outside their locus of control and this may mitigate against their capacity for behavioural change. Effective relationship-based work with families is essential to enable a better understanding of the way that closure interacts with other risk factors.
- Some parents find difficulty in engaging with a large number of professionals and may have limited capacity to understand the different roles and their contribution. This indicates the importance of a single lead practitioner with a key relationship with the family.
- Missed appointments, blocking of communications and cancelled visits are all indications of avoidant behaviour and require proactive follow-up.

T family

Partner agencies, including the children's school, reported mother's behaviour to be erratic and, on occasion, hostile. Assessments had not identified or addressed mother's trauma from mother's childhood experiences. Practitioners focused on mother's non-compliance with safety plans, particularly around contact with a partner who was the apparent perpetrator in domestic abuse incidents. A more strength-based, trauma informed approach could have enabled better support for mother and reduced harm to the children from emotional abuse.

K family

The K family were offered early help with concerns about low-level neglect, including the poor physical home environment. After the parents' initial consent to an Early Help Assessment, a 'Team Around the Family' found it difficult to arrange home visits and other appointments were missed. Work through a single Family Support Worker enabled a one-to-one relationship, during which disclosures about debts and possible criminal exploitation came to light.

Theme 3 – Critical thinking and challenge

Reviews frequently highlight a lack of 'professional curiosity' and 'over optimism'. Assessments and plans for support are framed by underlying assumptions that remain unchanged in spite of continuing or spiralling risk. This is particularly so where there has been intervention over a number of years. These circumstances are often combined with a lack of challenge between professionals and a reluctance to escalate concerns.

Key Learning from case reviews

- Practitioners should be confident in using the authority of their role to promote authentic 'support and challenge' relationships between practitioners and children and young people. This is essential in creating a climate of trust for courageous conversations about difficult issues, creating the motivation and opportunity for change. The capacity to build relationships in this way, and to apply critical thinking, can be limited for practitioners in situations where there are high and complex caseloads, with poor quality supervision.
- To help families identify goals and build on strengths to overcome difficulties, practitioners need to test assumptions about resilience and ensure appropriate support is in place.
- Positive self-reports of change need to be considered alongside reports and information from other practitioners.
- Strategy meetings, core groups and case reviews are contexts to analyse and challenge. Decisions to close cases, step down, or maintain at the same level need to be based on evidence of the positive impact of previous interventions or reducing risk.
- Critical thinking, particularly as part of reflective supervision, provides a framework for practitioners to exercise analytical skills to reframe and reassess their work with children, young people and families.
- Practitioners are often aware of escalation protocols but reluctant to invoke them. Where escalation protocols work more effectively, safeguarding partnerships have provided opportunities for practitioners to understand their different roles and promoted challenge as a key part of multi-agency working.

Baby N

Baby N was aged 11 weeks when his mother found him floppy and unresponsive, having earlier gone to sleep with the infant next to her on the sofa. At initial booking of her pregnancy, mother had stated she had previously participated in treatment for substance misuse but was no longer using cannabis. Practitioners built a positive relationship with her and wanted her and the new baby to do well. A lack of critical thinking meant that incidents of low-level neglect were rationalised. Mother's self-reporting that she had stopped the use of cannabis was not challenged in spite of limited evidence of her motivation to change and reported concerns from the local children's centre.

Family M

Family M were engaging with early help after the school had noted that the children were coming to school poorly presented and hungry. A 'Team Around the Family' meeting identified inadequate temporary accommodation as the key issue and sought to resolve the housing difficulty. This continued to be the main focus in spite of the emergence of other safeguarding issues. Some practitioners considered that the work with the family could be stepped up to children in need. When the decision was taken to close the case, their professional differences were recorded but not escalated as they were not confident of management support. The case review found that reflective supervision could have enabled practitioners to reassess their work with the family.

Theme 4 – Responding to changing risk and need

Weaknesses in risk assessment feature in the majority of case reviews. In many cases, initial assessments of risk have not been reviewed and updated in response to changing circumstances or taken sufficient account of the potential risk to children arising from known information about factors such as parental mental health concerns, adverse childhood experiences or criminality.

Key learning from case reviews

- A mindset of 'respectful uncertainty' supports the effective identification of risk factors and the mitigation of risk, underpinned by comprehensive assessment. This goes beyond the immediate presentation and takes account of any prior involvement with the family (for example if a previous child had been taken into care). Information from parental self-reporting needs to be triangulated.
- Up-to-date and appropriate evidence-based risk tools support assessment but they require critical reflection about the evidence to inform next steps.
- Pre-birth assessment is a 'reachable moment' to assess and mitigate risk, with co-ordinated support.
- In assessing risk in adolescents, it is important to understand and observe a 'risk trajectory'. Be aware of the possible impact of childhood trauma or prior neglect.
- Concerns about domestic abuse, parental mental health concerns and substance misuse are not sufficiently taken into account in assessing risks to children.
- Holistic family assessment needs to take account of any changing risk factors arising from extended family members (for example an adult joining the household following release from prison).
- The role of fathers/adult males is not sufficiently understood or taken into account in assessing risk. Practitioners should explore previous histories and involvement with children's social care, either in childhood or as parents, and inform the mother of the risks if appropriate. Consideration of fathers' supportive and caring capacity avoids a binary view of men as either good or bad.

Child H – Use of risk tools

Child H disclosed that she had been the victim of a series of sexual assaults following an alert to police by a minicab company. Previously, a CSE risk tool had been completed and the case was referred into the multi-agency child exploitation (MASE) process. The response to the escalating risks for Child H may not have been as proactive as it needed to be as practitioners focused on adherence to completion of the MASE process rather than linking it with wider child in need planning.

Baby R: Pre-Birth Assessment (PBA)

Baby R died in hospital after suffering non-accidental injury a few weeks after her birth. Mother had been under the care of mental health services since early adolescence. Father was being supervised by the community rehabilitation company. A decision to initiate the process was deferred as practitioners felt that the parents were cooperating with support plans. Earlier initiation could have brought together key information, holistic assessment of risks, and ensured an effective multi-agency plan to safeguard the unborn baby.

Child G: Role of male carer

Child G was brought to hospital after ingesting tablets prescribed for an adult. Mother had recently formed a relationship with a new male partner who was spending time in the household. He had a previous history of substance misuse and suicide ideation. Contact with his children from an earlier relationship was limited by court order. Although a number of professionals working with the family were aware of the relationship, there was no coherent understanding of his role and any assessment of the risks that he might present in his involvement with the family.

Theme 5 – Sharing information in a timely and appropriate way

Information sharing is a basic tenet in Working Together 2018. Constraints in systems and processes for accessing and sharing information between agencies are noted in national and local reviews. Lack of appropriate and timely sharing of information (particularly about siblings, domestic violence, substance misuse and mental health concerns) means that the nature of risk to the child is not recognised or acted upon. As a result, agencies act in isolation on the basis of known but incomplete information.

Key learning from case reviews

Thresholds for when to share information are not consistently understood and applied. Basic training for all practitioners needs to address a concern that GDPR and data protection regulations limit when information may be shared. This issue will be addressed in the forthcoming update to Working Together 2018.

- Lack of access by practitioners to IT systems outside their professional role limits sharing of information and can lead to a lack of accurate cross-service chronology. This is evidenced particularly in relation to health records held by GPs, health visiting, midwifery, CAMHS and adult mental health services.
- The development of information sharing capability between IT systems in partner agencies has the potential to offer a system-wide solution through the use of 'flags' and 'triggers' that prompt information sharing.
- Poor quality recording, inaccurate and out-of-date information result in partial understanding of the needs of the child. Considerations of risk are based on circumstances that may no longer apply.
- Timely circulation of minutes from multi-agency meetings provides reference points for chronology, decision-making, plans and evidence of progress to address safeguarding concerns.
- Information in reports about the observed circumstances of children needs to be jargon-free and avoid using generic phrases such as 'children doing well'. Inaccurate use of language does not support critical thinking and can give false assurances when viewed by other practitioners.



Child L

After the father's conviction for sexual offences against his own child (Child L), a review of the circumstances revealed that there had been concerns about the father's harmful sexual behaviour when he was an adolescent. Practitioners supporting the parents pre-birth and afterwards were not aware of father's previous history. A key learning point for practitioners was that the children's right to protection overrode father's rights in relation to confidentiality.



Baby Z

Baby Z's mother had a history of mental health concerns in adolescence and received support from the Peri-Natal Mental Health Team. A few weeks after Baby Z was born his mother began to experience mood swings and bouts of depression. One of these episodes led to an attempted overdose and emergency admission to hospital. Inaccuracies in the information at booking meant that mother's previous records were not accessed and her previous history of mental health concerns was not known. Mother minimised the seriousness of what happened and was subsequently discharged with no formal mental health assessment. A short time afterwards Baby Z was presented at hospital with injuries indicating that he had been shaken. This case showed the importance of accurate information, which was needed to trigger alerts to the GP and health visitor.

Theme 6 – Organisational leadership and culture for good outcomes

Effective organisational leadership within individual agencies, and across multi-agency partnerships, provides for the enabling systems processes and workforce development to support a practice culture that contributes to good outcomes. Senior leaders take a personal interest in learning and improvement activities and their impact. Funding constraints, high levels of vacancies and turnover, and high caseloads can make it more difficult for practitioners to sustain the direct work on cases to make an impact.

Key learning from case reviews

- Case reviews are an opportunity to identify and act upon improvements required in relation to key systemic enablers such as: improving practitioner and service capacity; the consistent use of shared, evidence-informed practice methodologies; and developing holistic approaches to assessment.
- Changes intended to improve practice and working cultures need to be supported by robust arrangements for implementation, particularly in support for workforce development and the associated systems and processes.
- Drift and delay in completing assessments and decision making are common features in case reviews. Wider system learning should also consider the impact of IT systems for recording and retrieving relevant information, and the extent to which administrative arrangements allow more time for direct work with children and families.
- Case reviews highlight the importance of management oversight to promote and assure practice standards. Reflective supervision has a pivotal role to support professionals in applying critical thinking, particularly in situations of high caseloads when practitioners can experience distress and loss of analytical capacity.
- Perceptions by practitioners about assumed service pressures (for example, high case numbers and limited staff capacity) can lead to a practice culture of working norms that are outside procedures, with reluctance to escalate concerns.



Embedding change

Following a recommendation from a previous case review, a safeguarding partnership looked to put in place more systematic early help arrangements. The transformational intent was to give practitioners more time for direct early intervention work and reduce the costs of expensive statutory interventions. Participation in a multi-agency development programme for the role of lead professional was good. The evaluation and follow-up of the impact of training was limited. A case review found that eighteen months on from the original initiative the lead professional role was not consistently understood and embedded in practice – a finding later confirmed from multi-agency audits commissioned by the partnership following the case review. The lack of an appropriate IT system for accessing information and case recording, and limited business support, were found to be key barriers to the take-up and effectiveness of the lead professional role.



Child J

At the time of his suicide Child J was receiving targeted mental health support organised through his secondary school, linked to a Children in Need (CiN) plan to address his increasingly erratic and challenging behaviour at home and in school. High staff turnover and vacancies limited management oversight. Access to high quality reflective supervision could have helped practitioners to keep an even keel, cope better with the pressures of completing tasks, and apply critical thinking.

6. A sense of new working arrangements

- 42. Working Together 2018 promotes the shared and equal duty of safeguarding partners, an emphasis on the child's experience and voice, and building a culture of reflection and learning.
- 43. The Panel continues to reflect on how local leaders have risen to the challenge of new multi-agency arrangements for child protection. We are interested in the extent to which partners are facilitating real time dissemination and embedding of learning.
- 44. Published yearly reports from safeguarding partnerships provide the Panel with an insight into the overall progress that has been made in implementing the new arrangements.

Safeguarding partnerships

There is a joint responsibility on the three safeguarding partners (defined in law as the local authority, clinical commissioning group and the chief officer of police for the area) to safeguard and promote the welfare of all children in a local area. Schools, colleges and other education providers have a pivotal role to play in safeguarding children too, alongside the other relevant agencies listed in regulations. Through safeguarding partnership arrangements, the safeguarding partners are required to ensure that they are fully engaged and involved.

Tripartite leadership of a learning system and its impact

- 45. Safeguarding partners have shown resilience, creativity and adaptability in taking forward the new partnership arrangements during the unprecedented challenges of the COVID-19 pandemic. Key areas of their work programmes have been delayed or deferred to ensure a focus on maintaining effective support for vulnerable children and families. The realignment with other multi-agency partnerships has enabled safeguarding partners to bring a sharper focus on a smaller number of priorities and practice themes, with a greater emphasis on quality assurance and learning. Although not named as statutory partners, local partners have been keen to include schools as a strong influence in multi-agency child protection arrangements. To demonstrate a new model of tripartite leadership, typically partnerships have established a pattern of high-level strategic meetings involving the safeguarding partners, along with some form of wider forum with relevant agencies, focused on problem solving 'wicked issues' and the dissemination of learning from audits and local reviews.
- 46. Some partners are making use of sub-regional arrangements to enable a more co-ordinated response to cross-cutting safeguarding risks such as criminal exploitation. Common child protection procedures and quality assurance arrangements across partnerships are emerging features.

47. Partnerships make good use of the feedback from consultation with young people by Health and Well-Being Boards and other partnerships. The strategic use of feedback from families is less well-developed. Partnerships have recognised the need to build capacity for feedback from children, young people and families in order to inform the overall partnership strategy and learning, with a number of innovative approaches being developed.
48. Independent scrutiny is a defining feature of the new arrangements. In some local areas independent scrutiny arrangements have only recently been developed. Partners are putting in place a range of approaches to independent scrutiny drawing on research evidence. In some areas, independent scrutiny is being delivered through sub-regional peer review. There is scope for further development work to identify the key features of effective independent scrutiny, drawing on learning from the different approaches being adopted by partners.
49. A few safeguarding partners have made explicit connections to research and evidence in determining their response to safeguarding priorities and changes in multi-agency practice. Partnership business plans would benefit from adopting an evidence-based approach, setting out the evidence base for their actions and decision-making.
50. Yearly reports have tended to concentrate on actions completed when reviewing their progress. More effective reports combine a review of the partnership business plan with a range of evidence sources about impact, these include data, audit reports, inspection evidence and practitioner feedback. These reports reflect openly on challenges, difficulties faced and aspects with a lack of progress.

Evidencing the added value of the new governance arrangements, and the impact of the partnership's work programme overall, are key areas for development in safeguarding partnerships.

Dissemination and embedding of learning in safeguarding children partnerships

51. Yearly reports are a valuable source of information for the Panel about the learning that is happening in local areas and how effective it is. Multi-agency audits are commonly used to evaluate the extent to which particular aspects of learning are becoming embedded. Partnerships are looking to establish innovative learning and improvement cycles, often linked to independent scrutiny processes.
52. Dissemination typically involves one of more of the following: briefing papers, case study material, training modules, bespoke learning events for practitioners, information on the partnership website and cascade (via 'train the trainers' or team briefings). Partnerships are looking to implement more systematic approaches through scheduled programmes of quarterly learning events or a practitioners' forum. The majority of yearly reports did not look at the impact of dissemination or measure its effectiveness. This is a notable gap.
53. Much of the learning for safeguarding partners is in rapid reviews, which are not intended for publication. Systems for sharing learning from rapid reviews across safeguarding partners are relatively under-developed. Our proposal to share an analysis of learning from rapid reviews on a quarterly basis will assist partners in sharing and disseminating learning.

Training and its impact

54. Multi-agency training plays a key part in the dissemination of learning by partners. Learning points and recommendations from reviews also relate to training on individual procedures, specific practice topics and more general approaches to working with families. Whilst yearly reports provide information about courses of multi-agency training and numbers of participants, the evaluation of the impact of training is generally very limited.

The evaluation of the impact of learning (including training) is a key area for development across safeguarding partnerships. This will be a focus for the Panel in 2021.

Safeguarding partners yearly reports

55. Working Together 2018 (WT 2018) requires safeguarding partners to publish a report at least once in every twelve-month period. The intention is to **'bring transparency for children, families and all practitioners about the activity undertaken' [by the safeguarding partners]... The report must set out what they have done as a result of the arrangements, including on child safeguarding practice reviews, and how effective these arrangements have been in practice.'**

The Panel asked What Works Children's Social Care to evaluate the extent to which the published reports from safeguarding partnerships (68 out of 121 partnerships as at January 2021) met WT 2018 requirements.

56. We have found that WT 2018 requirements were fully or partly evidenced in 50 of the 68 yearly reports that the Panel had received in January 2021. There were 18 reports that did not evidence the WT 2018 requirements. These reports provided little or no coverage of most of the areas set out in WT 2018, for example about the impact of the safeguarding partners on outcomes for children in relation to early help, looked after children and care leavers.

WT 2018 requirements

- Evidence of the impact of the work of the safeguarding partners and relevant agencies, including training, on outcomes for children and families, from early help to looked after children and care leavers.
- An analysis of any areas where there has been limited or no evidence of progress on agreed priorities.
- A record of decisions taken by the partners in the report's period (or planned to be taken) to implement the recommendations of any local or national child safeguarding practice reviews, including any resulting improvements.
- Ways in which the partners have sought and utilised feedback from children and families to inform their work and influence service provision.

[WT 2018, Chapter 3 paragraphs 41-46]

57. Yearly reports for partnerships are intended to be shorter, more focused on impact, with more scope for local variation in terms of structure and publication format (unlike the LSCB annual reports in which prescriptive national requirements about content were considered to have encouraged lengthy and largely descriptive reports). We have found considerable variation in the length of report and the detail provided. There were differing interpretations of the content required and depth of information needed to cover the areas specified in WT 2018. Some reports have focused primarily on the work of the statutory partners, with technical appendices providing performance data. An alternative approach has been to provide hyperlinks to other related documents.

Overall, our analysis suggests the need for yearly reports to have a sharper focus on impact, evidence, assurance and learning.

7. Quality of reporting and reviews

58. The Panel collects a range of data to maintain oversight of safeguarding notifications and the system of national and local reviews. Our concern is to ensure that the system enables local leaders to reflect, learn, and change practice.

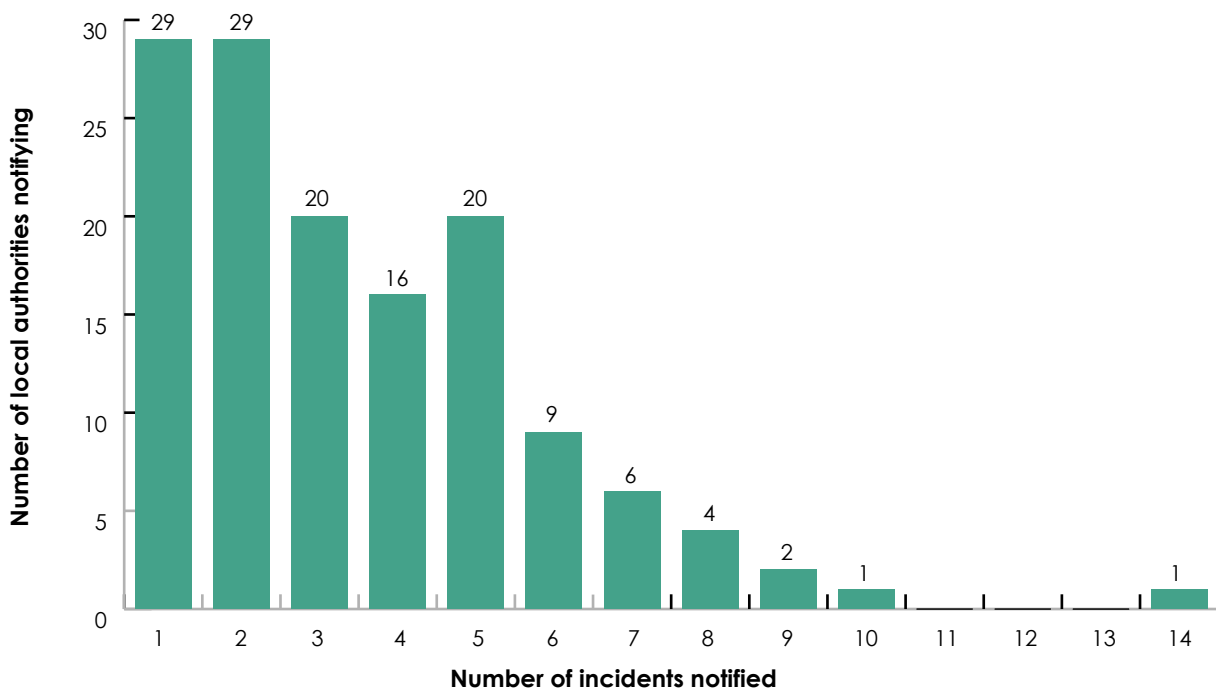
Serious Incident Notifications

59. A local authority is duty-bound to notify the Panel, and by extension the Department for Education and OFSTED, if it knows or suspects a child dies or is seriously harmed, and abuse and neglect is known or suspected.

60. As in 2018-19, most local areas (43%) notified the Panel of between three and six cases per year. There were one or two notified cases from 38% of local areas. The variation in the number of notifications between local areas to some extent reflects their differing socio-economic contexts and child population sizes. There were 14 local areas (9%) that notified seven or more cases during the year. There were six local areas that made no notifications to the Panel. The Panel is having exploratory conversations with these local areas to understand the reasons for this and what can be learnt for other local authority areas.

Graph 4

Number of Serious Incident Notifications per local authority area



61. Our examination of the pattern of notifications over the past three years indicates that there is considerable variation in the how the criteria for serious harm are interpreted. There needs to be clarity about what triggers a notification in one case rather than another. The notifications of death and serious harm that have been most open to varying local interpretation have related to SUDI, suicide and some criminal harm such as knife wounds. In these instances, the decision rests on the understanding of the causal links between the death or harm and any abuse or neglect that may have been experienced. We recognise that this is a complex matter. We will engage with safeguarding partners to understand better the issues, including whether the guidance about notification would benefit from greater clarification.

Timeliness of rapid reviews

62. Rapid reviews are expected to be completed within 15 working days of the serious incident notification to the Panel. The data for timely completion of 445 rapid reviews with a requested completion date⁴ in 2020 is shown below.

Table 6: Timeliness of rapid reviews 2020

Working days range	No. of rapid reviews received	No. of rapid reviews not yet received as at March 2021	Totals	%	2018-19 comparator No. of reviews (%)
1-15	94	0	94	21%	239 (51%)
16-25	193	0	193	44%	142 (30%)
26-59	104	0	104	23%	35 (7%)
60+	30	24	54	12%	57* (12%) * 38 not received
Totals	421	24	445	100%	473 (100%)

⁴ Rapid reviews with a requested completion date in 2020 include reviews for incidents notified in 2019 and the date for completion within 15 days fell in 2020. Similarly, there are notified incidents in 2020 where the expected completion date for the rapid review falls in 2021.

63. With the need for safeguarding partners to prioritise the most vulnerable during the COVID-19 pandemic, the Panel recognised that having a 15-day target for undertaking and reporting a rapid review may not have been achievable if partner agencies could not be drawn together. An authorised extension of the 15-day target for completion of rapid reviews operated between April and September 2020. Timeliness data excluding the extension period is shown in Table 7. Table 8 below shows timeliness data during the April – September authorised extension period.

Table 7 - Timeliness of rapid reviews January 2020 to March 2020 and October 2020 to December 2020

Working days range	No. of rapid reviews received	Rapid reviews not yet received as at March 2021	Totals	%
1-15	55	0	55	28%
16-25	84	0	84	42%
26-59	39	0	39	20%
60+	7	13 (64 – 280 working days)	20	10%
Totals	185	13	198	100%

Table 8 - Timeliness of rapid reviews during relaxation period April 2020 to September 2020

Working days range	No. of rapid reviews received	Rapid reviews not yet received as at March 2021	Totals	%
1-15	39	0	39	16%
16-25	109	0	109	44%
26-59	65	0	65	26%
60+	23	11 (118 – 247 working days)	34	14%
Totals	236	11	247	100%

64. The pressures during the COVID-19 pandemic significantly affected the overall timeliness of rapid reviews in comparison with 2018-19. In the extension period 60% of reviews were completed within 25 days – 10% lower than for the months outside the relaxation period. Across the whole year, the completion of reviews within 15 days was markedly reduced from the previous year. The proportion of reviews taking longer than 25 days was significantly higher than twelve months ago. Our expectation remains that it is essential for rapid reviews to be completed within 15 days, and for that learning to be disseminated and acted upon. Reviews completed 2-3 months after the incident lose impact and value.

Quality of rapid reviews

The Panel commissioned a qualitative review of a rapid reviews and LCSPRs by a team of researchers from the University of East Anglia and the University of Birmingham. They analysed 135 rapid reviews (a 25% sample of rapid reviews completed in 2020) and 34 LCSPRs received by the Panel between October 2019 and December 2020. The findings from the review are incorporated into the analysis below.

65. The quality of rapid reviews is too variable. The most effective reviews benefit from the influence of senior leaders in promoting a culture that welcomes criticism and recognises the importance of challenge to drive improvement. The direct input of senior leaders provides direction about how services will develop and change in response to learning from a particular case. Reflective analysis balances out what went well, factors outside the control of the agencies involved and lessons for future work. They identify immediate learning, how and when that learning can be disseminated across the partners. There is a clear rationale for the decision about whether to initiate an LCSPR, and sufficient analysis to identify areas for further exploration. As a result, the partners are in a strong position to bring about change and improvement.

Some safeguarding partners are beginning to make good use of the learning and reflective questions from our national reviews within their local reviews and as a starting point to inform their own analysis.

66. In the less effective rapid reviews we see, there continues to be too much detailed chronology and insufficient analysis to inform either immediate learning or aspects for review through an LCSPR. Often, there is crucial detail missing about the family, with the ethnicity of the child and family a common omission. Analysis and reflection are limited, with unclear lines of sight from the analysis to the conclusions.

From rapid review to LCSPR

67. After completing rapid reviews in respect of the 482 serious incidents notified to the Panel in 2020, the safeguarding partners were proceeding to an LCSPR in 167 cases (35%), had decided not to undertake a local review in 278 cases (58%), and had not yet reached a decision in 37 cases (8%). An LCSPR was more likely to be initiated in cases of direct maltreatment deaths and extra-familial assaults/homicides (47%) than in deaths related to but not directly caused by maltreatment (38%) or non-fatal serious harm cases. Partnerships are increasingly making more nuanced decisions about whether new learning will result from undertaking an LCSPR, taking into account relevant learning from the Panel's national thematic reviews and the Department for Education triennial analysis of Serious Case Reviews.

In 2020 the Panel saw 464 rapid reviews. We agreed with 69% of the decisions by safeguarding partnerships to either initiate or not to initiate an LCSPR. More usually this occurs where the Panel considers that an LCSPR should be undertaken. The Panel also challenges safeguarding partnerships where the local decision has applied criteria for undertaking an LCSPR without taking account sufficiently whether new learning would result from the review.

68. Where a safeguarding partnership has decided not to undertake an LCSPR, the most frequent reason for not doing so is that the partnership has already carried out several reviews concerning the same issue and new learning is unlikely.
69. Rapid reviews sometimes propose alternative review methodologies instead of undertaking an LCSPR. If the purpose of the review is to identify new learning, the review must be deemed an LCSPR and meet the requirements in terms of timescale for completion and publication. The status of a review as an LCSPR does not limit the scope for creativity and innovation in the approach to learning, the analysis, and dissemination. **If a rapid review has indicated that there is more learning to be gained, safeguarding partners should move to an LCSPR. There are no other types of review needed or allowed within WT 2018.**

Quality of LCSPRs

70. Since the system of rapid reviews and LCSPRs was established in 2018, there have been 257 LCSPRs initiated up to the end of December 2020. The number of LCSPRs increased from two in 2018, to 72 in 2019 and 182 in 2020⁵. Partnerships are required to notify the Panel seven working days before an LCSPR is published. There is no requirement to notify the Panel when an LCSPR is completed. Up to the end of 2020 the Panel had received 33 LCSPRs. Of these 33 LCSPRs, 15 have been published, 14 have an intention to publish and four are not intending to publish. Timescales from initiation to publication varied, with 13 reports published more than 200 working days after initiation of the review.
71. LCSPRs provide an opportunity to explore the analysis and practice themes from rapid reviews in more depth. Effective LCSPRs have a clear rationale for the scope, building on the rapid review, with focused and succinct review questions. The methodology is appropriate for exploring the identified themes, allowing for incorporation of the views of children and families, and the involvement of practitioners. The report gives a sense of the distinct context for the child and what their daily life was like. Its analysis includes an outline summary of why relevant decisions were taken by professionals, with critical reflection on the way in which agencies worked together and any shortcomings identified. There is a clear line of sight from the evidence to the conclusions. Any implications for national policy or practice are highlighted. Learning from the review is linked to specific, measurable, achievable, relevant and time-bound recommendations. A dissemination plan includes targeted learning for senior managers and practitioners.

⁵ The total for LCSPRs initiated in 2020 includes decisions relating to incidents notified to the Panel in 2019.

72. Many of the LCSPRs seen by the Panel to date are structured and read like traditional Serious Case Reviews with insufficient focus on inquiry and learning. As with the weaker rapid reviews, the weaker LCSPRs provide lengthy chronologies, more limited analysis and a plethora of recommendations that lack specifics. LCSPRs should be written in a style that is suitable for publication (suitably anonymising the family and circumstances). The requirement that LCSPRs are written for publication means that they are available for all practitioners and the wider public. The Panel continues to be concerned about the relatively limited number of LCSPRs that have been published and will continue to challenge safeguarding partnerships about their decision-making in relation to publication. Without publication of LCSPRs, learning is not shared, and a key precept of the learning system is weakened.

The Panel will look to hold solution-focused 'round table' discussions with safeguarding partners and wider stakeholders, to consider the issues highlighted in our report about the timeliness and quality of reviews.

8. Priorities and 2021 work programme

73. The Panel has agreed a number of priorities which will inform and shape its work programme over the next one to two years. We want in particular to:

- explore how best to make sure that the voice and perspectives of children and families are at the heart of safeguarding reviews and system learning
- enhance appreciation of the impact of culture, race and ethnicity on safeguarding practice
- extend ways in which the Panel engages with local and national leaders and policy makers, maximising its influence through timely and effective communications.
- assess our impact so that we better understand the difference we make and how we can enhance our contribution
- develop, with others, our approach to learning and change, so that learning is effectively embedded

Programme of work 2021-22

74. The Panel currently has plans to deliver the following programmes of work in 2021-22:

National Panel programme of work 2021-22	
National reviews	<p>1. Non-Accidental Injury (NAI) in Under-1s</p> <p>This review is giving particular focus to the role of men since they are often the perpetrators of NAI and too often are 'invisible' to services. It is an area where there is very little research evidence. The review is including interviews with a small group of men who have been convicted of this type of offence. Analysis of these interviews, together with the outcomes of stakeholder discussions, case analysis, and a literature review, will provide the basis for the review report. This is due to be published in June 2021.</p>

National Panel programme of work 2021-22	
Thematic and practice analysis	<p>1. Supporting vulnerable children and families during COVID-19</p> <p>The Panel undertook a thematic analysis of rapid reviews reported to the Panel during the initial COVID-19 outbreak between March 2020 and September 2020. A practice briefing was issued in December 2020, followed by a well-attended webinar in January 2021. Further thematic analysis will be undertaken on cases we have seen from October 2020 to March 2021.</p>
	<p>2. Safeguarding children who are not visible to schools</p> <p>The Panel has received a number of reviews about children who were harmed or died and who were also electively home educated. Our focus will be specifically on those children who are vulnerable to safeguarding risks if they are not at school. We will analyse these cases to examine the extent to which elective home education has been a factor in the serious harm or death of a child.</p>
	<p>3. Safeguarding children at risk of criminal exploitation – Follow up to 2020 CCE report</p> <p>We are now following this up with a 'Phase 2' examination of CCE cases received by the Panel since the report was published. We will evaluate implementation of the review's findings, identify good practice and survey wider national work.</p>
Thematic and practice analysis	<p>4. Domestic abuse</p> <p>We are scoping this review in recognition of the salience of domestic abuse in so much child safeguarding practice. It will also respond to the Ministry of Justice response to the consultation on assessing risk of harm to children and parents in private law cases, which recommended that the Panel conduct a statutory national practice-based review of domestic abuse cases in private law children proceedings.</p>
	<p>5. Risk assessment and decision making</p> <p>The Panel has identified risk assessment and decision-making as a critical cross-cutting theme in the reviews it has received. It is a feature of many historical inquiries about children who have died or been seriously harmed.</p>
Research	1. Observatory report - Quantitative review of SINs and RRs
	2. Observatory report - Qualitative review of rapid reviews and LCSPR
Stakeholder engagement	Systematic, regular communication with the sector through a quarterly newsletter, practice briefings, webinars and round table events.
Panel annual report 2021	An analysis of the patterns in practice and key messages from national and local learning, and the Panel's priorities for 2022.

9. The Panel at work

Our role

75. The Panel plays a key role in the leadership of child safeguarding practice. It seeks to do this in the following ways:

- **System oversight: Maintaining oversight of the system of national and local reviews and how effectively it is operating.** The Panel receives all rapid reviews produced by safeguarding partners and provides feedback on the decision whether to conduct an LCSPR. This helps to ensure consistency across the system. On occasions the Panel disagrees with a 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 the partners to understand and help with their decision-making processes.
- **System learning: Identifying and overseeing the review of serious child safeguarding cases which, in our view, raise issues that are complex or of national importance.** The Panel does this by commissioning national reviews of cases where the themes are considered to be of national importance and has begun to commission specific pieces of thematic analysis based on trends from rapid reviews. For example, in the year 2019-20 it commissioned research into the impact of COVID-19 on child safeguarding. As more LCSPRs are completed and published, the thematic analysis of learning from LCSPRs will become an increasingly important feature of the Panel's work.
- **System leadership: Identifying improvements to practice and protecting children from harm.** In this regard, the Panel seeks to share its insights and the learning from reviews through its communication and stakeholder engagement programme. For example, following the research of the impact of COVID-19, the Panel shared its first practice briefing with key stakeholders and safeguarding partners to ensure learning was cascaded back into frontline practice.

76. More widely, the Panel works in a cross-governmental context and with a range of other stakeholders to contribute to and influence the development of research and policy on child safeguarding practice. **The examples below, taken from our work during 2019-20, illustrate the Panel's widening contribution:**

- Research in Practice partnership conference.
- Attending the No10 Hidden Harms Summit in May 2020 to share insights on safeguarding children during the pandemic.
- Feeding into the National Child Mortality Database (NCMD) thematic report on suicide and attending regular NCMD roundtables on the subject.
- Responding to the Independent Anti-Slavery Commissioner's call for evidence on the Modern Slavery Act (2015) regarding child criminal exploitation.
- Giving evidence to the Independent Inquiry into Child Sexual Abuse (IICSA).
- Scoping some work on domestic abuse as a result of the Ministry of Justice response to the consultation on assessing risk of harm to children and parents in private law children's cases
- Working with the Home Office and Department for Education on safeguarding children and young people at risk of serious violence following the recommendations of our first national review (criminal exploitation).
- Working with Public Health England and Department of Health on the recommendations following our second national review (sudden unexpected infant death).

Communications and stakeholder engagement

77. Throughout 2020, the Panel has sought to increase its communication and engagement with stakeholder bodies and safeguarding partnerships. To date, it has done this through setting up a quarterly newsletter, creating a Twitter account, and running a series of webinars.

- Our first webinar in August 2020 focused on sharing information about the Panel's national reviews and conducting LCSPRs.
- Our second webinar in January 2021 focused on a thematic analysis of rapid reviews relating to serious child safeguarding incidents reported to the Panel during the period of the initial COVID-19 outbreak.

78. Panel members have also attended several stakeholder conferences and events at local and national level to ensure learning is cascaded through their networks. These include:

- National Children and Adults Services Conference
- Child Safeguarding Reform Policing Conference
- NHS Safeguarding (East of England event)
- Principal Children and Families Social Work Network (Yorkshire and Humber)
- Leeds Health Safeguarding Advisory Group
- The Association of Safeguarding Professionals webinars
- The Department for Education Innovation Programme regional events
- Network of Named and Designated Healthcare Professionals

The Panel has also been featured on stakeholder podcasts and blogs, including What Works Centre for Children's Social Care podcast, Social Care Institute of Excellence blog, and the Association of Child Protection Professionals podcast.

79. In the next year, we want to build on the work-to-date by increasing the reach of our communications channels and providing more opportunities for engagement through quarterly practice briefings and Panel-run virtual events, as well as stakeholder channels and events.

We are taking three specific actions to support this ambition.

- 1.** We will identify a Panel member to link to safeguarding partners in each of the nine English regions to support discussions on issues of mutual interest.
- 2.** We will gather, analyse and share data and learning quarterly from rapid reviews and LCSPRs, so that valuable insights and practice themes can be disseminated more quickly to support improvements locally and nationally.
- 3.** We have commissioned an external organisation to undertake research and intelligence gathering through discussion with safeguarding partners and other stakeholders. This will help us understand better the impact of the Panel's work and what could be done to improve communication.

We will continue to assess and adapt our approach to communicating and discussing learning in a way that is agile and responsive to changing circumstances.

Effective system learning

- 80.** Going forward, the Panel has been considering further how it will progress its aim to make the safeguarding system more effective and more efficient. We want to ensure that we are able to distil learning from rapid reviews and LCSPRs; we are seeking to find more meaningful ways to disseminate that learning and to influence policy and practice. We are not minded to commission too many national reviews without evidence that we, and the system as a whole, has the capacity to respond. However, we want to ensure that the approach we take for reviews is optimised to system learning.
- 81.** We are keen to develop a shared understanding of how our national and local systems can learn together. Our perspective is that change happens at a number of levels:
- An individual changes his/her practice in response to new learning.
 - A group, whether a professional group (i.e. a community of health visitors, nurses, police officers etc.) or a constructed group (a set of professionals working in a particular area), make changes to their practice in response to new learning.
 - The system as a whole, (multi-agency leaders across health, social care, education, legal and law etc.) agree whole system change to more effectively address safeguarding needs and therefore make changes to practice as result of new learning.
- 82.** Change also occurs at different times and in different ways. Change can emerge from the practice developed by an individual, that is then shared with a professional community, leading to system change. Such change is often described as 'organic', this definition also extends to the idea that a system is made up of different parts and that in order to function to best effect, each part must also function to best effect.
- 83.** Change can occur at the national policy level (sometimes through government directive) and this brings about a system wide change at operational level. The principle is that the system level change, leads to a change in the way in which groups are constructed and hence how individuals behave. We recognise that the safeguarding community comprises professional groups and communities but also that much depends on the way these communities are led.
- 84.** Our mission, working with others, is to develop and embed a learning culture where agencies at every level are honest when things go wrong, where partners are properly held to account without scapegoating, where there is time and determination to reflect and learn, and where that learning translates quickly into policy and practice.

10. Annex – About the Panel

About the Child Safeguarding Practice Review Panel

- The Child Safeguarding Practice Review Panel is responsible at a national level for identifying and overseeing the review of serious child safeguarding cases which, in its view, raise issues that are complex or of national importance. The Children and Social Work Act 2017 provides for the creation of a new Child Safeguarding Practice Review Panel. The Panel is appointed by the Secretary of State for Education but is independent of Government.

Our remit can be summarised as follows:

- We are responsible at a national level for identifying and overseeing the review of serious child safeguarding cases, which, in our view, raise issues that are complex, or of national importance. 'Serious child safeguarding cases' are those in which:
 - abuse or neglect of a child is known or suspected; and
 - the child has died or been seriously harmed
- 'Serious harm' includes serious and/or long-term impairment of children's mental health or intellectual, emotional, social or behavioural development. It should also cover impairment of physical health. This is not an exhaustive list. When making decisions, judgment should be exercised in cases where impairment is likely to be long-term, even if this is not immediately certain.
- We have a shared aim with safeguarding partners in identifying improvements to practice and protecting children from harm. We share concerns, highlight commonly recurring areas that may need further investigation (whether by local or national review or some other mechanism), and share learning, including from success, that could lead to improvements elsewhere.
- We seek to establish consistency of practice and to that extent operate as a system adjudicator.
- We act as catalysts for change and our unique national perspective enables us to see patterns and note areas that require further investigation and consideration.
- We aim to influence and shape the work of safeguarding partners. The development of child safeguarding practice will be brought about primarily through daily practice with families.

Appointments to the Panel

- We were appointed following an open public recruitment. We are appointed as independent individuals, not representing any particular interest. The Chief Social Worker for Children and Families in England is a standing member of the Panel.
- In line with the Nolan principles on public life, we have declared any aspects of our work that may be perceived to present a potential conflict of interest. As members, we also work in accordance with the Panel's terms of reference and code of practice. When there is a conflict of interest is declared by a Panel member they are withdrawn from case discussion.

Who we are

Chair: Annie Hudson

Annie Hudson was appointed as Chair of the Child Safeguarding Practice Review Panel in December 2020. A social worker by background, she has been a practitioner, educator and researcher, and a children's services leader.

She served as Strategic Director, Children's Services for Lambeth London Borough Council and previously as Strategic Director of Children's Services for Bristol City Council. Whilst at Lambeth, she co-lead the development of the borough's youth violence strategy and regional adolescent safeguarding work for the Association of London Directors of Children's Services.

She is a member of the What Works Centre for Children's Social Care advisory board and is also a trustee at The Social Care Institute for Excellence (SCIE) and at Oxfam GB.

Panel members

Karen Manners QPM

Karen was appointed to the Child Safeguarding Practice Review Panel in June 2018. From March 2020 until December 2020, she served as interim chair to the Panel. She was Deputy Chief Constable of Warwickshire Police, and has over 32 years of experience in policing, receiving a Queen's Police Medal (QPM) for services to policing in the fields of child neglect and vulnerability. Karen has experience in public protection work including child abuse investigations; she was also head of CID for Hampshire Police; national lead for child neglect and national lead on the vulnerability agenda leading to the first national vulnerability action plan for all 43 forces in England and Wales.

Sarah Elliott

Sarah was appointed to the Child Safeguarding Practice Review Panel in June 2018. She has 38 years clinical and leadership experience in the NHS including Regional Chief Nurse for NHS England South. Sarah is also the pan island chair of the safeguarding partnerships in the Channel Islands, an external assessor with the College of Policing and a special advisor with the CQC.

Mark Gurrey

Mark was appointed to the Child Safeguarding Practice Review Panel in June 2018. Mark is a qualified social worker and has practiced for 37 years. He has spent 20 years in senior management positions and the last 10 years working as a leader in several authorities in intervention. He is currently also Improvement Adviser and Chair of Sandwell Improvement Board.

Peter Sidebotham

Peter is Emeritus Professor of Child Health at Warwick Medical School. He has over 20 years' experience as a consultant paediatrician and academic specialising in child protection, including 15 years as a designated doctor for safeguarding in Warwickshire prior to his retirement in October 2018. Peter is co-editor of Child Abuse Review and trustee of the Association for Child Protection Professionals (formerly BASPCAN).

Dale Simon CBE

Dale was appointed to the Child Safeguarding Practice Review Panel in June 2018. She is a qualified barrister (currently non-practising) with over 20 years' experience of child abuse prosecutions and policy development.

She is currently a Non- Executive Director at the Parole Board and was previously the Director of Public Accountability and Inclusion at the Crown Prosecution Service.

Dr Susan Tranter

Susan was appointed to the Child Safeguarding Practice Review Panel in June 2018. She is Executive Head Teacher of Edmonton County Schools and Chief Executive of Edmonton Academy Trust. She is a member of the Audit and Risk Committee of the Office of the Children's Commissioner. She was a member of the expert panel of the Timpson Review of School Exclusion.

Isabelle Trowler

Isabelle took up her post as the Government's first Chief Social Worker for Children and Families (CSWCF) in September 2013 and sits on the Panel in this capacity.

Since qualifying as a social worker in 1996 from the London School of Economics, Isabelle has held a variety of practice and senior leadership roles within the voluntary, statutory and private sector.

Role of the pool of reviewers

A pool of reviewers assists us to review the case information, undertake analysis and provide support national reviews. Reviewers are selected for individual reviews through open and fair competition. If there are no reviewers in the pool with suitable availability or experience to undertake a review, we may select a person from outside the pool.

We have 24 reviewers registered on our pool and **their details are available here**. They cover a broad range of experience across children's social care, health, police and legal professions. We have refreshed the pool to enrich and expand the expertise and capacity and we will continue to run recruitment rounds. If you are interested in joining the pool, please let us know at: **Mailbox. NationalReviewPanel@education.gov.uk**.

